STATE OF MICHIGAN
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
CERTIFICATE OF NEED COMMISSION

COMMISSION MEETING

BEFORE JAMES FALAHEE, CHAIRPERSON

333 South Grand Avenue, Lansing, Michigan

Thursday, June 15, 2023, 9:30 a.m.

COMMITTEE MEMBERS:	AMY ENGELHARDT-KALBFLEISCH, D.O. ERIC FERGUSON, M.D. DEBRA GUIDO-ALLEN, R.N. DONALD HANEY (via Zoom) ASHOK KONDUR, M.D. LORISSA MACALLISTER, PH.D. RENEE TURNER-BAILEY
MICHIGAN DEPARTMENT OF ATTORNEY GENERAL:	MR. BRIEN WINFIELD HECKMAN (P76006) Assistant Attorney General PO Box 30736 Lansing, Michigan 48909 (517) 335-7632
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES STAFF:	TULIKA BHATTACHARYA MARCUS CONNOLLY BETH NAGEL TIFFANI STANTON KENNETH WIRTH
RECORDED BY:	Marcy A. Klingshirn, CER 6924 Certified Electronic Recorder Network Reporting Corporation Firm Registration Number 8151 1-800-632-2720

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Thursday, June 15, 2023 - 9:39 a.m.

MR. FALAHEE: Okay. Why don't we go ahead and get started. We're glad that Commissioner Turner-Bailey and Commissioner Kondur are here because they are the quorum. So thank you very much for being here and now we know it's raining out so we'll extend the meeting until the rain is over, however long that takes. So there. Thank you very much for being here.

I'll call the meeting to order at whatever time it is. My name is James Chip Falahee. I'm the chair of the Commission. And the first item on the agenda is the review of the agenda and that agenda came out to us yesterday, I think, with the final agenda.

MR. WIRTH: Final agenda came out on Tuesday.

MR. FALAHEE: Okay. The days blur together.

MR. WIRTH: They do.

MR. FALAHEE: Thank you, Kenny. So that's in front of us. We need a motion to approve that agenda that came out to us on Tuesday. I'll entertain a motion to that effect.

DR. MACALLISTER: Commissioner Macallister, so moved.

MR. FALAHEE: Great. Thank you.

MS. GUIDO-ALLEN: Guido-Allen, second.

MR. FALAHEE: Thank you. Motion made and seconded to approve the agenda. All in favor say "aye."

ALL: Aye.

MR. FALAHEE: Any opposed? Great. The agenda goes.

(Whereupon motion approved at 9:40 a.m.)

MR. FALAHEE: All right. Next item, declaration of conflicts of interest. As always, given the items that are on the agenda that has just been approved, does anyone have a conflict of interest they want to declare? The answer is no. So we'll continue to move forward. Next, the review of minutes. Last meeting we had was January 26. Our March meeting was cancelled so we're looking at the meeting minutes of January 26. Any questions or comments? Otherwise I'd entertain a motion to approve those minutes.

DR. FERGUSON: Moved.

DR. ENGELHARDT-KALBFLEISCH: Engelhardt-Kalbfleish, second.

MR. FALAHEE: Motion on the floor to approve the minutes. All in favor say "aye."

ALL: Aye.

MR. FALAHEE: Opposed? Okay. Great. They go forward.

(Whereupon motion passed at 9:41 a.m.)

MR. FALAHEE: Before we start with our first

agenda item, we received this morning at our chairs three separate letters, comments, whatever. And for those of you that have been around in these meetings, you know what I'm about to say. For those of you that are new to the attendees, you'll hear what I'm about to say, and that is that the commissioners, the chair especially, don't like last minute submissions and the reason is because if we get something handed to us at the time a meeting is beginning or as we're supposed to be listening to a witness or talking about a matter with each other, it's not fair to us or to those that we're talking with or listening to, to expect us to review something that's just been handed to us. Okay? So I don't want to disappoint those that knew I would have to say something, but I think out of deference to the people that come in as witnesses and the deference to the commissioners being able to do their job, getting us items ahead of time is much better. Thank you.

With that, the first item on the agenda is the CT informal workgroup with a final report and draft language coming up. And, Kenny, I'll turn it over to you and then our witness is Dr. Ryan, the chair of the workgroup. Is Dr. Ryan here?

MR. WIRTH: He's on Zoom today.

MR. FALAHEE: Okay. Great.

MR. WIRTH: So I'll introduce this first. So we

held a informal workgroup for the CT review standards. This workgroup didn't seem very contentious to us, worked to a consensus pretty quickly we thought with CT.

So we at the Department are adding some technical edits to the CT review standards on how -- what the workgroup is recommending. We are adding the definition for a referring licensed health care professional and replacing some instances with the term "physician" with a new definition to allow for the documentation of projections by licensed health care professionals working within their scope of practice. We are also including a technical edit across all the standards in front of you today that we -- we did discuss at the January Commission meeting to add a requirement that a notification is sent to the Department at least 30 days before any planned decrease or discontinuation of services so that we can be aware of that plan. That's what I have on that so I can pass it over to Dr. Ryan on Zoom.

MR. FALAHEE: Let me ask, does anybody, any of the commissioners have any questions of Kenny at this point? Okay. Great.

MR. WIRTH: All right. Dr. Ryan, if you are on Zoom, you are welcome to give your report.

DR. RYAN MADDER: Thank you, Kenny. Can everybody hear me okay?

MR. WIRTH: Yes. And I can turn you up a little bit.

MR. FALAHEE: We're going to increase the volume, Dr. Ryan. This is Commissioner Falahee. So hang on one second until we -- there we go. Okay. Go ahead.

RYAN MADDER, M.D.

DR. RYAN MADDER: Thank you. So thank you, everybody, for having me today. My name is Mike Ryan. I am a radiologist with Advanced Radiology in Grand Rapids, and the medical director for adult radiology at Corewell West, and the chairperson for the informal CT workgroup.

So as Kenny said, the workgroup met a total of four times from September to December, and, you know, we went through the charges given to us by the Commission, and it was, as Kenny said, not particularly contentious. There was, you know, unanimous, you know, agreement on all of the charges and the recommendations that I have before you today, not really any particular disagreement. As I'll get to in just a second, charge number two probably generated the most discussion and generated a subgroup meeting that took place after one of our meetings, but the recommendation for that charge ended up being unanimous and, as I said, there wasn't really any disagreement to that charge at all. And so I will quickly run through the charges that were set forth by the Commission and then what we decided as a

workgroup.

So charge one was to consider adding the abbreviation "CTE" to the definition for CT equivalents. The group discussed that. There was not really any discussion to be had. We felt that this was a pretty straightforward technical change. And so we had the group draft language that amended section two, just adding CT -- CTE as a side definition for CT equivalents just to clarify the language a little bit which you can see in the final report and that recommendation was unanimously approved by the workgroup. Any questions about that charge at all?

MR. FALAHEE: No. I don't see any, Dr. Ryan. Go ahead.

DR. RYAN MADDER: Okay. Charge two, as I said, was probably the most -- generated the most discussions. That was to consider expanding the definition for CT scanner to further elaborate on what is not considered a CT scanner, you know, the use of chiropractic, use of dental (inaudible) CT and chiropractic offices, you know, ear, nose and throat physicians offices, ortho -- orthopedics offices, et cetera. And so I said -- as I said, this generated a little more discussion and necessitated us forming a subgroup. That subgroup met. The discussion was pretty unanimous. There wasn't really any disagreement. We, you know, considered the possibility of deregulating the cone beam CT, but

ultimately decided to not make any changes to the definition of what's considered a CT scanner and still require a CON application for non-dental use of cone beam CT. The group felt that deregulating the use of cone beam CT would, you know, prove difficult --

MR. WIRTH: Dr. Ryan?

DR. RYAN MADDER: Yes.

MR. WIRTH: Could you try speaking up a little bit or closer to the mic maybe?

DR. RYAN MADDER: Yeah. Of course, yeah.

MR. WIRTH: Thank you.

DR. RYAN MADDER: Is that a little bit better?

MR. WIRTH: A little bit, yes.

DR. RYAN MADDER: Okay. Sorry about that.

MR. WIRTH: No, you're good.

DR. RYAN MADDER: So the group ultimately decided to not make any changes to the definition of -- of what is considered a CT scanner for the purposes of a CON application. The group felt that, you know, deregulating it would be -- would, you know, cause a lot of, you know, increased use of the cone beam CT in, you know, non-dental uses and even potentially could increase imaging utilization and cost. You know, the examples that we came up with were, you know, in-office limited CTs often results in additional diagnostic CTs and we felt that that could actually drive up

imaging utilization and cost.

So, as I said, the subgroup and overall workgroup unanimously decided to not make any changes to what the definition of a CT was and added some language in section two to further clarify that, that any use of CT scanners with the exception of dental usage still required a CON application which you can see in the final report. And that change was unanimously approved. Again, not really any disagreement about that charge, even though we ended up having a subgroup for that. Any questions about that charge at all?

MR. FALAHEE: Any questions from the Commissioners to Dr. Ryan about that? No questions, Dr. Ryan, so carry on.

DR. RYAN MADDER: Okay. Perfect. Charge three was to consider adding language for lease renewal for CT similar to the MRI standards. And this, again, resulted in the unanimous decision by the workgroup. Not really any disagreement about this. And so section five was amended to include the addition of renewing a lease of an existing CT within the application process and then some technical language just defining what renewal of a lease meant with regard to the CT scanner which you can see in the final report as well. And this recommendation was unanimously approved as well.

MR. FALAHEE: Any questions of the Commissioners about that item? Okay. You're on a roll, Dr. Ryan. Keep going.

DR. RYAN MADDER: Charge four was to consider adding language that would prohibit the withdrawal of a commitment during the review process, again, similar to the MRI standards. Both of these last two charges were to bring the CT standards somewhat in line with the more recently updated MRI standards. And, again, no real, you know, disagreement on this. This was unanimously approved to add technical language just defining that the Department would not consider withdrawal of a signed commitment on or after the date that the application was deemed submitted. And then subsequently in the next section that would consider a withdrawal of this commitment if a request was written in writing before the application was deemed submitted. And this charge was, again, unanimously approved by the workgroup.

MR. FALAHEE: Commissioner Ferguson?

DR. FERGUSON: Ryan, thanks. This is Eric Ferguson. I just want to make sure I understand. So the notion that pledged a volume can't be withdrawn during the review process, does that extend after the review process? So at what point can they be withdrawn or can they never be withdrawn?

DR. RYAN MADDER: I would defer to Kenny on that question. We -- we're talking during the review process? I am not sure of the -- the work flow after it's been approved.

MS. BHATTACHARYA: This is Tulika. If I could answer that question? So, Dr. Ferguson, when the application is submitted to us and we start the review process, like we deem it submitted and start the review process, we are saying none of the submitted forms by the physicians can be withdrawn.

DR. FERGUSON: Okay.

MS. BHATTACHARYA: And obviously if we have gone through the whole review process and the director has approved the project, commitment cannot be withdrawn because our decision has already been issued based on their signed commitment forms.

DR. FERGUSON: And I presume we have safeguards in place so that those volumes can be recommitted elsewhere to double count or whatever?

MS. BHATTACHARYA: Yes.

DR. FERGUSON: Okay.

MS. BHATTACHARYA: Once a physician commits to an application, it is committed for three full years.

DR. FERGUSON: Okay. That's what I wanted to -- thank you.

MS. BHATTACHARYA: And we do track those.

DR. FERGUSON: Thank you.

MR. FALAHEE: This is Commissioner Falahee. We've seen that game trying to be played many, many years ago. And I know Walt Wheeler is here and Walt and I both experienced that many years ago so that's why we put in the three-year rule to prevent that gaming. Any other questions about that charge? Okay. Dr. Ryan, charge five.

DR. RYAN MADDER: Thank you. So charge five was kind of a blanket charge just to consider any other technical changes that were, you know, from the Department or updates to the standards. And the group felt that there were no other -- no need for any additional recommendations, you know, or changes to the standards apart from the charges that we've already discussed and that was also unanimously -- unanimously approved as you can see in the report.

MR. FALAHEE: Any questions at all from the Commissioners? Commissioner Ferguson?

DR. FERGUSON: Dr. Ryan, this is Eric Ferguson again. This may actually be pertaining depending upon how the recommended changes are organized. The work that you've done, Dr. Ryan, looks great from my perspective. The charges all look great. I think that it's well thought out, well worked through. That's perfect. My question pertains

to the 30-day notice that has been proposed by the Bureau to incorporate. Seems okay on the surface, but I guess I'd like to hear a little bit more because I think that there's at least some objection to that and I'd like to hear a little bit more about the pros and cons before being asked to support or object.

MR. WIRTH: Beth or Tulika, the 30-day notice?

MS. NAGEL: Sure. Okay.

MR. WIRTH: Thank you.

MS. NAGEL: Yeah. So the 30-day notice stems from the January meeting of the Commission. And there was a -- it was a very long meeting and there was a very long debate and discussion about the -- this particular 30-day notice. And it was the Department's -- our emphasis was not to have this be punitive in some nature or to cause some issue. We are just asking when there is a planned decrease in service and we completely understand there are many times that there -- it is not a planned decrease. But where there is a planned decrease, if part of the process could include notifying the Department. That gives us a much better handle to give to you on what's operating where. And so that is really our only emphasis is just a data collection point. I'm quite surprised at some of the pushback. I think perhaps it's reading a little bit more into it than the actual emphasis or the actual intent behind the

language. At the January meeting the Commission told us to put it in the standards going forward and so that is why it appears in the standards and didn't go through the workgroup process like the other pieces of language.

MS. GUIDO-ALLEN: Commissioner Guido-Allen. So I think that what might be, is the ambiguity around "planned decrease." So many of us that have oversight over imaging departments, whether it's inpatient or outpatient or a combination of both, we are struggling with workforce. And there might be a day when we decrease the number of appointments available. Is that going to trigger a notification? So I think that's what we need is a little bit more clarity around what is a planned decrease.

MS. NAGEL: Thank you so much for that and I did want to point out it says "planned decrease or discontinuation." I think we're most concerned on the discontinuation part. And so certainly if the -- if it were the Commission's -- you know, the Commission wanted to take out "decrease" and leave it at "discontinuation," we would also be comfortable with that.

DR. FERGUSON: I guess what -- what -- I support the general philosophy of what we're trying to accomplish. I also support the concern living in that space, but we're going to be trying -- trying that. So I -- I appreciate both sides of this. I guess I would urge some caution on

going to elimination because one could go to such a decrease that it can't begin. And I would favor giving you some latitude or revising the language in other ways to soften it and make clear that it's not punitive. It's not around staffing crises or whatever.

MR. FALAHEE: Yeah. This is Commissioner Falahee. That -- those of us in the health care world, we live this every day and we sometimes don't know 'til we show up at 7:00 in the morning do we have the staff we need. And sometimes obviously that's not planned and I never thought the Department was going to come down and say, "oh, you didn't tell us." So I'm comfortable with the words "as is" given the explanation. The one question I would have is sometimes we know something is planned but we haven't yet told staff and I'm sure many in the room have had that happen. If we must notify the state and I get why, is that a public report that curious staff might be able to find out about?

MS. NAGEL: Yes. Anything given to the state, to any one of us in writing is a public document and would require a Freedom of Information Act and we would turn over that information.

MR. FALAHEE: But you might not turn it over within 30 days.

MS. NAGEL: Well, we do our best.

MR. FALAHEE: Thank you. Okay.

MS. NAGEL: I will say, you know, so right now, just maybe for a little bit of context, we generally find out something has discontinued or dramatically decreased annually with our annual survey. That's really how we normally find out this information. We're asking for a way to find out before the annual survey with a little bit more frequency. So, again, I think, you know, we're open to 30 -- to changing the 30 days. We're open to anything. Our goal is to find out before the annual survey. Tulika, did you have something?

MS. BHATTACHARYA: Yes. This is Tulika from the Department. And to address Commissioner Guido-Allen's question, it is not at all about notifying the Department about your staffing changes. It is -- and we can make it clear. It is about discontinuation of pure services. For example, you have ten operating rooms at your hospital and you have decided to permanently de-license two of them or one of them. We are not being notified of that. Or let's say you have 11 CT scanners at your hospital, you decided to uninstall one or two of them, we are not always notified of that. So we are talking about those type of decrease or discontinuation in CON-covered services and equipment. It's not about staffing, it's not about any other support, you know, services connected to your CON-regulated equipment and

rooms.

DR. ENGELHARDT-KALBFLEISCH: Commissioner Engelhardt-Kalbfleisch. I know a few of my fellow commissioners have brought up the workforce sensitivity. I believe during the January meeting Commissioner Ferguson brought up could we -- could sites notify within 30 days of discontinuing, so after, as opposed to before, which I think -- I -- I appreciate why the Department wants to know before the annual data, but I think that would address some of the workforce sensitivities that -- that we keep reflecting.

MS. NAGEL: Thank you. Just so I -- I want to make sure I'm clear. You're saying where we say "at least 30 days prior," you're saying within 30 days --

DR. ENGELHARDT-KALBFLEISCH: Yes.

MS. NAGEL: -- of the planned decrease? Okay.

DR. ENGELHARDT-KALBFLEISCH: That would, I think, eliminate the concern about the workforce challenges that we're all seeing (inaudible).

DR. FERGUSON: So that would mean up to 30 days after?

DR. ENGELHARDT-KALBFLEISCH: Yes.

DR. FERGUSON: (inaudible).

MR. FALAHEE: Right.

DR. ENGELHARDT-KALBFLEISCH: Yeah. I think

that's -- yeah.

DR. FERGUSON: I think that's fine. That's reasonable.

MR. FALAHEE: Would that -- would that -- this is Falahee. Would that accomplish, Tulika, what the Department is after if we did it within 30 days after?

MS. BHATTACHARYA: Thank you. It will. I mean, for hospitals and other established healthcare providers it's not an issue, but it may be a problem -- and I'm not sure -- for freestanding facilities, like a single service like a CT scanner or (inaudible). Just for your information, right now I can say there are two or three facilities we're trying to get ahold of somebody to submit their annual survey data and we cannot find anyone. There is no contact. The agents are no longer linked to them and so that is the other side of this story. So we are fine within 30 days. It should be okay for -- for the most part.

DR. FERGUSON: Follow-up question. So within 30 days sounds great. Are there any circumstances wherein a provider of a licensed CON service can be blocked from shutting it down? Because if it occurs 30 days after, you no longer have the option to block that. And I'm not saying that there should be, I just don't know. I have no idea.

MS. NAGEL: Yeah. That's a great question, one that has come up in multiple different ways before so I

think I know the answer, but I would request Assistant Attorney General Brien Heckman to correct me if I'm wrong. But there's nothing that the state can do to compel continuation of a service.

MR. HECKMAN: Right.

MR. FALAHEE: Other questions of Dr. Ryan or the Department? Dr. Ryan, this is Commissioner Falahee and I want to thank you and for steering this workgroup and having unanimous votes on everything. I want to know how you did it because then we'll learn from you for future SACs and workgroups. But, no, thank you for -- for your time, for the members of the workgroup's time. It's a very good report and I want to just thank everybody for that. So that was -- it was well done. If you have the time, I'm going to ask if there's any public comment and then maybe if you want to address the public comments, Dr. Ryan, you can. So I don't know if we have any public comment on this. Kenny?

MR. WIRTH: Yes, we do. First up I have Melissa Reitz, McCall Hamilton.

MELISSA REITZ

MS. MELISSA REITZ: Good morning. I'm Melissa Reitz with McCall Hamilton. I am guilty of dropping off a letter in front of you guys, but I did e-mail it to you yesterday afternoon in an attempt to not be in violation of Chip's rule so there was a huge debate about it.

This morning I am speaking to you on behalf of Henry Ford Health System. Tracey Dietz was not able to be here this morning, so she actually sent me with a letter from former Commissioner Denise Brooks-Williams to read into the record so I'll just do that really quickly.

"Dear Commissioners,

Henry Ford Health would like to offer comments on language requiring 30 days notice to the department if a service will be decreased or discontinued. The language reads:

'The applicant shall provide notice to the department of any planned decrease or discontinuation of service(s) at least 30 days prior to the planned decrease or discontinuation of service(s).'

Henry Ford Health appreciates the need for ongoing communication with the Certificate of Need team and strives to do this whenever possible. However, sometimes there are reasons where advance notification to the state may not be in the best interest of patient care. It could put staffing levels at risk, jeopardizing access, and quality.

The draft language has been added to CT, Psych Beds and Nursing home draft standards up for vote by the commission today.

Henry Ford Health encourages the CON Commission to

not support this language in the standards up for vote today.

Respectfully, Denise Brooks-Williams."

I will add, aside from the letter, that in my discussions with Tracey at least they are supportive of this concept of within 30 days and I think that is a nice compromise. So, thank you. I'm happy to answer any questions you have. All right. Thank you.

MR. WIRTH: Next up I have Dave Walker of Corewell Health.

MR. FALAHEE: And then while -- while Mr. Walker's coming up, think about whether we need to make a motion to edit the 30 days within instead of before.

MR. WIRTH: Got you covered. Okay.

DAVE WALKER

MR. DAVE WALKER: Good morning, Chairman Falahee and members of the CON Commission. My name is Dave Walker and I am here on behalf of Corewell Health. And after all that discussion I can just take my written (indicating) -- I'll make this easy on you. Corewell Health is supportive of the concept of the 30 days notification, that language. We don't support the language as written. Thank you very much. I'm happy to take questions.

MR. FALAHEE: That's the first time I've seen statements thrown out. Thank you. Any questions of Mr.

Walker? Okay. Great.

MR. DAVE WALKER: Thank you.

MR. FALAHEE: Thanks a lot. Any other cards or comment?

MR. WIRTH: I don't have any for CT, no. But I -- I will say if anyone's planning on providing public comment later, please get those blue cards in to us as soon as you can. That'll help us with --

MR. FALAHEE: Okay. While we deal with a hot mic, this is Falahee. Any Commission discussion? We still have Dr. Ryan on the line if -- if you have any questions for him about the content of the recommendations. Any questions at all? Okay. Before we go to proposed action, I will remind everyone that if we choose to take proposed action and we have a motion to that, then the language would go to the public hearing and to the Joint Legislative Committee. And that's -- that's how we handle it for these proposed motions -- proposed language. But before I do that, since we have seven Commissioners in attendance, I wanted to turn to Attorney General Heckman to say what -- what's the quorum requirement? We've got a quorum, but how many of us seven need to vote in favor of this or any other action to move it forward? So, Brien, I'll turn it to you.

MR. HECKMAN: Assistant Attorney General Brien Heckman. So to -- to send the proposed language for

public -- sorry. Hello? To send the proposed language to public hearing after which it comes back to the Commission, it only requires a majority of the Commissioners present. For final action, so once it comes back, that requires a majority of the Commissioners serving.

MR. FALAHEE: Okay. So looking ahead, all of the actions we have today are proposed, none are final. So for purposes of today's meeting we need at least four people to vote in favor of -- okay. So no Commission discussion. I'd entertain a motion to approve the proposed language, send the language as a draft to public hearing and to the Joint Legislative Committee, and regarding the 30-day language I would include within that a motion, or I'd entertain a motion to make it 30 days within versus the 30 days before pursuant to our earlier discussion. Would anyone care to make that motion?

MS. GUIDO-ALLEN: Guido-Allen. I propose that motion that Chip just said.

MR. FALAHEE: Thank you.

DR. ENGELHARDT-KALBFLEISCH: Commissioner Engelhardt-Kalbfleisch. Second.

MR. FALAHEE: Thank you. Okay. We have a motion on the floor. Any discussion? Commissioner Ferguson?

DR. FERGUSON: Sorry. 30 day within, does anyone care then that then somebody can't tell you 60 days in

advance, 90 days in advance if it -- okay. Depends what you --

MS. GUIDO-ALLEN: At least.

DR. FERGUSON: -- well, so at least or within. Right. So I don't -- I mean, I don't really care. I think it's a great proposal. I'll support it. I just don't know how technically you get in the language on that one and I don't want anyone to object when it finally comes through 31 days before.

MS. NAGEL: That's a great point. If we said the applicant shall provide notice to the Department of any planned decrease or discontinuation of service at least 30 days after.

MS. MELISSA REITZ: No, you don't want to say that. Because that could be 31 is more than 30 so you'd be okay. You want to say no less than 30 days after.

DR. FERGUSON: No later than 30 days after discontinuation of services.

MS. NAGEL: Any planned decrease or discontinuation of services no later than 30 days after the planned decrease or discontinuation of the service.

MR. FALAHEE: I will -- would anyone care to amend the motion to say that?

MS. GUIDO-ALLEN: Guido-Allen.

MR. FALAHEE: And then?

DR. ENGELHARDT-KALBFLEISCH: Second, Engelhardt-Kalbfleisch.

MR. FALAHEE: Okay. Great. Thank you Commissioner Ferguson. Are we all set on the wording and what's in front of us?

MR. WIRTH: No, you're good. I just want to confirm before we make our vote. We're saying no later than 30 days after the planned decrease or discontinuation?

DR. ENGELHARDT-KALBFLEISCH: Correct.

MR. WIRTH: Correct. Okay. And just so everyone knows, there will be a public comment period, we'll have a public hearing. We still have time to workshop this a tiny bit and get the semantics right. Beth?

MS. NAGEL: So I had a bird on my shoulder tell me that the word "planned" is no longer needed. I think the word "planned" provides a little bit of a safeguard for the providers and so I would be inclined to keep it.

DR. ENGELHARDT-KALBFLEISCH: Yes.

MR. FALAHEE: Yes. Okay. I think we're set on the draft wording to be hacked at in public comment. So I'll -- let's call for a vote then. All in favor of the proposed motion, please raise your hand.

ALL: (all raise hand).

MR. FALAHEE: Okay. Everyone raised their hands so we have unanimous approval of that.

(Whereupon motion passed at 10:11 a.m.)

MR. FALAHEE: Dr. Ryan, again, thank you very much and thank you for all the work the workgroup did and that you did and we'll be sure to call on you again so we can get unanimous approval of whatever charges we send your way. Thank you very much.

DR. RYAN MADDER: Thank you. Thank you very much, everyone.

MR. FALAHEE: Okay. Next we have Commissioner Haney who is wearing a different hat. And what I'll do is turn it over to Kenny -- I think I've got the hot mic. Yeah, right. So, there. Okay. That's better. What I'll do is once Kenny takes care of the hot mic that I had, let him summarize what's going on and then I'll see if the Commissioners have any questions about Kenny's intro and then we'll turn it over to Commissioner Haney who is wearing the hat of the chair of the workgroup to present. And I know that Commissioner Haney is on -- on the Zoom call. So, Kenny, I'll first turn it over to you, please.

MR. WIRTH: Thank you, Chip. So Nursing Home Hospital Long-Term-Care Units, we held a workgroup to investigate the charge that was presented by the Commission and formed at the January meeting. There were multiple contentious issues on this charge. It was a lengthy workgroup. We scheduled an additional meeting to

accommodate a need to continue working towards consensus. The issues that we identified at the Department that we're somewhat concerned about that we aren't in support of right now, we aren't supporting a proposal to add language regarding extensions for public health emergencies within Nursing Home CON review standards. We think that if there's a need to address extensions in these standards or other circumstances, the regulation itself, the public health code, should be modified to make these extensions applicable to all standards. We think that a piecemeal approach to project extensions within individual standards reduces consistency across our CON standards. We are also not supporting the proposal to add language in sections seven and nine that would allow a facility to temporarily close in order to replace all existing beds. The proposed language was not approved by a section external to CON within the Department when we consulted with them as experts in long-term care. There were multiple concerns and possible loopholes that hadn't been addressed yet. There wasn't a limit to how far residents could be moved while the construction was ongoing. There wasn't a limit to the number of facilities that could undergo this process at the same time. They were just concerns that we had that we felt needed to be addressed before the language was ready to be moved forward. Further, the Department's currently willing

to work with applicants on a case-by-case basis to address concerns related to replacing aging structures while using our discretion to ensure that access to and quality of care are maintained for existing residents. We don't see this issue as widespread and requiring urgent action at the moment. And, again, we're willing to work on a case-by-case basis with applicants who want to go through this process. That's my intro to that.

MR. FALAHEE: Okay. Any questions of Kenny before we turn it over to Commissioner Haney wearing his hat as the chair of the workgroup?

DR. MACALLISTER: Kenny, just curious how you deemed it not needed to explore further the inquiry about the number of beds or access for those beds, that the quality of care wasn't being impacted? How did you deem that?

MR. WIRTH: For which?

DR. MACALLISTER: The last part of what you were saying.

MR. WIRTH: For sections seven and nine?

DR. MACALLISTER: Uh-huh (affirmative). How did the Department deem that?

MR. WIRTH: In which, which part of --

DR. MACALLISTER: So when you were talking specifically you said the Department deemed it that it

was -- there wasn't an issue to explore that further.

MR. WIRTH: We -- so, yeah, we don't see it as a widespread issue. We don't have --

DR. MACALLISTER: Right. That's why I'm asking what -- what part of -- why -- how was that determined?

MR. WIRTH: We don't have multiple -- we don't have, like, you know, 20 homes coming to us right now saying, hey, --

DR. MACALLISTER: So it's based on inquiry from the community that's saying there's no issues if that's what you're saying?

MR. WIRTH: Correct.

DR. MACALLISTER: But it's not necessarily based on the data of what is available if access or quality scores of some sort?

MR. WIRTH: It's -- we don't see it as rising to the level to require this type of action without making sure that we have consensus around the language and that all possible, you know, --

DR. MACALLISTER: Got it. Okay.

MR. WIRTH: -- loose ends are tied up. You know, we are willing to work with people if they come to us and we can work on a plan together. But to get this language that was presented into there, we think there would be more issues than solutions if that language was implemented right

now.

DR. MACALLISTER: Okay. Thank you. Sorry. I didn't say "Commissioner Macallister," so --

MR. FALAHEE: Other questions? That issue may come up again during public comment. I'm not sure. Okay. Seeing no other questions or hearing none at this point, I'll turn it over to Commissioner Haney. Don, the floor is yours and I think you're on Zoom, so let's make sure we can hear you and we get rolling.

MR. HANEY: Good morning. Can you hear me okay?

MR. FALAHEE: Yup, you're good. Thank you.

MR. HANEY: Good. Thank you.

DON HANEY

MR. HANEY: I'd like to start by thanking Kenny and the Department, as well as the members of the workgroup for all of their work during the process. As Kenny mentioned, it was a lengthy committee meeting. We added a committee meeting to try to wrap up the last couple of areas and just weren't able to get those wrapped up the way we had hoped. But I thank them all for their hard work and their input and attending the meetings.

Our first charge -- we started in September of '22 and ended on April 13th of 2023. Charge number one was just a review of definitions for clarity and consistency and was completed by the Department and the team. Charge number two

reviewed adding a requirement that the previously approved change of ownership for CHOW must be 100 percent complete before replacement and relocation and the team -- the workgroup was able to come up with consensus on that in the draft language. Any questions on charge two?

MR. FALAHEE: I don't see any, so keep moving.

MR. HANEY: All right. We'll keep going. Consider charge three. Consider alternative means of collecting and reviewing nursing home citation data and that was completed as well by looking at the survey reports for facilities. That was pretty straightforward I think. Charge number four, review multiple sections for the ability to broken into subsections. Everyone felt that that was a great idea and helped clarify and make -- made getting through the standards a little easier, and so that was also completed with consensus. Charge number five, review adding language regarding the QAAP, PASSAR and CMP requirements for renewable lease applications. This was an area that was a little contentious, but we were able to, I think, find language that everyone was comfortable with and one of the, I think, compromises that we came up with was that anyone that had a applicant that had a Michigan Department of Treasury plan shall not be considered delinquent for the purpose of this section. So if they were actively working with the Department this -- the Treasury on a payment plan

if they were behind or had been delinquent, that that would be considered current for the purposes of this section and that really related to the quality assurance assessment program, preadmission screening, PASSARs and then civil monetary penalties. So let me stop with that one and see if there's any questions on charge number five.

MR. FALAHEE: Any questions? This is Falahee. Any questions from the Commissioners? Don, you did a great job of explaining it. I wondered why this was in there and now, now I understand. So thank you.

MR. HANEY: You're welcome.

MR. FALAHEE: Any questions? No questions so proceed.

MR. HANEY: Okay. Charge number six is actually quite similar to charge number five. Again, we're adding language that a payment plan agreed upon by the applicant and the Michigan Department of Treasury shall not -- shall be considered not delinquent for the purposes of this section, again, so that those two standards were consistent. And that, too, was completed with consensus.

MR. FALAHEE: I don't see anyone with questions on that so keep going.

MR. HANEY: Charge number seven. As Kenny already mentioned, we really weren't able to come up with language that met with consensus on adding language to ensure beds

are oriented in the proper manner. So we left that one with really no changes. And then charge number eight was another charge that we had some good discussion on and some disagreement on. The Department continues to have some concerns understandably, so -- regarding the public health epidemic as Kenny has already noted. So this was completed without consensus and so there are no changes to the language although those -- some of the proposed language has been in my report for your consideration to look at, but, again, the Department had their concerns. Any questions on charge number eight?

MR. FALAHEE: Any questions from the Commissioners about that? I see Commissioner Ferguson reaching for the microphone, so --

DR. FERGUSON: I'm going to retreat to charge number seven. Maybe this is for Kenny, maybe this is for you, Don. It's my understanding you weren't able to achieve consensus on the appropriate manner for assuring that beds are used for what they're supposed to be used for. Do we have other safeguards in place?

MR. WIRTH: So I can answer that. This is Kenny with the Department. The general sense of the workgroup was that this one was more in the lane of Licensing and Regulatory Affairs to determine what those parameters are.

DR. FERGUSON: So we have it over there? That's

fine. Thank you.

MR. WIRTH: And they are required. There's the state survey manual that LARA uses that has a lot of that in there, so they felt that that was adequate.

DR. FERGUSON: That's fine. I just wanted to make sure we had some safeguards somewhere.

MR. WIRTH: Yes.

MR. FALAHEE: Other questions? This is Falahee still. To Kenny or you, Don, on the issue of charge eight. As I understand it on public health, what you're saying is, Kenny, to summarize you, your statement, we don't want to do one-offs, you know, this standard, this standard, that. If we're going to do anything at all, if we need it at all, do it for all and we may not need anything at all. Is that correct?

MR. WIRTH: Correct. And this -- this was -- this charge was specifically dealing with project extensions or the proposal was. I think that this charge arose because we have something in I believe it's the MRI standards that deals with volume requirements that are impacted by a public health epidemic but that's not detailed in the public health code how we do those maintenance volume requirements. But this one with the extensions being in the public health code it's more difficult for us to walk that line of when are we interfering with the public health code and when are we

creating the standard that's our own determination.

MR. FALAHEE: So I guess devil's advocate question. If unfortunately we have another pandemic and there's a public health emergency and that impacts extensions or whatever, I guess at that point it's up to the Department's discretion or the wording of the public health emergency as to what to do or not to do?

MR. WIRTH: Correct. And one of our concerns was, you know, define the public health epidemic. I mean, there's other epidemics going on that are not to the level of COVID that impact the ability to complete projects. So that was one of our concerns is having that discretion, determine when it is actually impacting what the providers are trying to do.

MR. FALAHEE: Okay. Great. Thank you.

DR. MACALLISTER: Chairman?

MR. FALAHEE: Yeah. Commissioner?

DR. MACALLISTER: Commissioner Macallister. Just as a follow on to that and, and I guess that was what I was trying to probe at, at the beginning and the onset in regards to our primary purpose is access and I know during the public health epidemic there was a considerable amount of reduction of access. And so I was just wondering if there was a way to consider that role of maintaining proper access for the service during that epidemic that would at

least under, I mean, preclude that opportunity to not be impacted as it was?

MS. NAGEL: Yeah. I would just add this specific language is about project extension.

DR. MACALLISTER: Right.

MS. NAGEL: So it's projects that aren't at this -- that are in process, that are being implemented. And this specifically was a supply chain issue where we couldn't get the things we needed for construction.

DR. MACALLISTER: Right; right.

MS. NAGEL: And we have rules in our administrative rules to deal with those types of things to add time or to add -- you know, make amendments to projects and things like that. And we would not want to cite something in the standards that would take away the discretion of the Department in our rules and so that was really the issue that we're getting at.

DR. MACALLISTER: Yeah. And I understand that. I'm just wondering if there's any way to say that the beds that are licensed would be maintained that were compromised or something. So does that make sense?

MS. NAGEL: Because we're talking about projects that are being implemented, we're not talking about necessarily nursing home beds being taken on or offline. It's a delay in the project being implemented.

DR. MACALLISTER: Implemented. So it's not -- there's not a lack of beds at the time. You're saying they're additive beds?

MS. NAGEL: I'm saying that they're additive beds. I'm saying that they don't have a patient in them.

DR. MACALLISTER: Uh-huh (affirmative).

MS. NAGEL: At the moment.

DR. MACALLISTER: At the moment.

MR. FALAHEE: And let's say that the planned construction deadline was June 15th.

DR. MACALLISTER: Right.

MR. FALAHEE: Because of supply chain issues --

DR. MACALLISTER: Right.

MR. FALAHEE: -- an extension is needed to take it to hopefully to October 15th. The Department wouldn't take the beds away. They would say, "okay, you need more time because of the public health emergency. Your extra time is granted."

DR. MACALLISTER: And all I was thinking is there -- I understand that because we had that experience in the construction and architecture industry a long amount of time. So I -- I get that piece. But I think the duration of that time as an emergency order, that opportunity to say you -- we need them still in the system, understand that there's a delay, but is there a way to still provide it if

needed? But maybe not. It's probably immaterial.

MS. NAGEL: So -- so part of the issue also is when there -- if there were a emergency order in place -- this isn't a question. When there's an emergency order in place, we follow that order.

DR. MACALLISTER: It supercedes that.

MS. NAGEL: Yes.

DR. MACALLISTER: Exactly; 100 percent.

MS. NAGEL: This -- why we are hesitant -- another reason why we are hesitant in this particular place is that if we go down a path of defining the types of emergencies that could potentially impact construction, we're going to leave something out.

DR. MACALLISTER: Oh, totally.

MS. NAGEL: And so we really felt like it made more sense to leave it open, not try to define what types of things would hold up construction in other types of projects and to continue to give the discretion to the Department that exists in our administrative rules.

DR. MACALLISTER: Right. I think ultimately just to provide that access is important and maintain that access during that -- that delay. So -- okay.

MR. FALAHEE: Other questions through number eight? Still got some to go. Okay. Don, back to you for charge nine.

MR. HANEY: Okay. Charge number nine was kind of a late add to the discussion in the workgroup. I think it was generally felt that had the workgroup had more time or we had started this discussion a little sooner, we might have come to consensus on this particular charge and on some language. However, we did conclude the workgroup on -- without consensus on this particular charge. Overall, the workgroup was looking for some language to allow beds to be taken offline while construction is being done and there were a number of access concerns as Kenny has already noted previously. And so this charge was completed without consensus. The workgroup also felt that it should be a priority or something looked at for the next review or SAC that is formed for long-term care.

MR. FALAHEE: This is Falahee. I think we'll have more discussion about that my guess is during public comment. Okay. All right.

MR. HANEY: Yes.

MR. FALAHEE: All right. Don, go -- one more charge, I think?

MR. HANEY: Yes. And charge number ten is the standard charge and completed with consensus after review by the Department. And that completes my report. Again, I apologize for not being there with you all today. Just a number of conflicts this week. But I appreciate the time to

present the report.

MR. FALAHEE: This is Falahee. Thanks, Don, for -- for presenting and for -- for being here if only on Zoom and we're glad you did that. Again, thank you for leading the workgroup given your expertise. I think it was a great result and good consensus was reached. And thanks to everybody in the workgroup. Let me open it up to public comment. Do we have any public comment?

MR. WIRTH: I have one public comment from Rich Farran of HCAM.

MR. FALAHEE: Thank you.

RICH FARRAN

MR. RICH FARRAN: Thank you, Chair Falahee and Commissioners for the opportunity to provide some brief public comment this morning. Rich Farran with HCAM. We represent 360 nursing facilities across the state. I'd also like to thank Commissioner Haney for his leadership on the workgroup and all of the Department staff. I think it was a great process sharing language back and forth between meetings and doing our best to find resolution at the informal workgroup meeting.

So as Commissioner Haney already went through, I think we're at about not quite as good as the CT, but at a 80 percent clip of consensus on our charges. So I think that was due to the leadership of Commissioner Haney and all

the great work from the stakeholders and the Department.

So we are supportive of the draft recommended language from the Department today, but remain concerned, I'll think you'll be unsurprised to hear, with the proposed language not being included for charge eight and charge nine. I think we had -- there was just a good discussion on both of those charges. I'll briefly touch on charge eight and the need for the extensions during the public health emergency. Again, this was touched on in the discussion that the group just had.

The challenges for nursing facilities during the pandemic are well documented. The clinical challenges really at the start directed all the resources that providers had to just the resident and keeping up with the ever changing guidelines from the federal and state government. And in the ensuing economic climate coming out of the pandemic I think is well documented as well. The workforce challenges and the supply chain challenges that really caused delays outside of the provider's control. So we certainly respect the Department's position of having the discretion to look at these extensions and wanting to remain consistent with the public health code. The reason we would like to continue to consider this language, I would ask the Commission to do so. We had members who did have CONs expire or withdrew during the pandemic because of those

delays that were outside of the control. The language that was proposed that was included in Commissioner Haney's report we attempted to give -- maintain that discretion with the Department. That language required the provider to offer evidence that the PHE was causing delays beyond their control and if the Department determined that that evidence was sufficient, those extensions would be appropriate. So we would just like to continue to have the conversation around charge eight as well as charge nine. Michigan leads the nation in renovations and new builds. We would like to continue to incentivize updating our facilities. It's what the market dictates. It's what we should do for our residents as Michigan ages. So we share in the Department's concerns of any displaced residents if a building is temporarily closed for those -- the duration of that construction and we shared some language that hopefully would get to that. So we look forward to continued conversation about that.

MR. FALAHEE: Thank you. Questions from the Commissioners? Okay. So this is Falahee. I'll have one. Not yet for you, sir. But Kenny -- well, don't leave yet because you may have more to say. Nice try.

MR. WIRTH: You don't get off that easy.

MR. FALAHEE: Yeah; right. Comments, Kenny, or the Department over there to -- to what he said?

MR. WIRTH: No, I don't think so. I did appreciate the back and forth we had. I think we had some really constructive conversations and e-mails going back and forth trying to arrive at that consensus but we just didn't get there with this workgroup. There was still work that needed to be done, make sure we closed all the possible holes that were in there.

MR. FALAHEE: Okay. And that -- that's where my head is at, you know, and I think Commissioner Haney said the same thing. If, you know, had we had more time -- don't we all wish that for lots of issues? But I think these issues aren't easily resolved or quickly resolvable and it -- it's good to have a back and forth discussion and I think next time maybe we can do that. When are these next up for review in the normal cycle? What I'm ask- -- what I'm --

MR. WIRTH: I think it's 2025. Let me make sure, though. It is 2025. So October 2024 there will be a public comment period for that.

MR. FALAHEE: Okay. That -- that -- personally that's where I'm -- I'm one Commissioner. That's what I'm thinking about. And because I know the Department is sensitive as you are and that your association to what do we with the residents when there's construction going on. And I think -- I'm hoping we can work through that and then if

there's still issues come October '24, we'll see you back here.

MR. RICH FARRAN: Thank you. Appreciate that. And just echo Commissioner Haney just if this could be a priority if that doesn't actually meet standards, we'd appreciate it.

MS. GUIDO-ALLEN: Great; great.

MR. RICH FARRAN: Thank you.

MR. FALAHEE: Any other questions? Thank you very much.

MR. RICH FARRAN: Thank you.

MR. FALAHEE: Other public comment?

MR. WIRTH: That was the only blue card we have for this topic.

MR. FALAHEE: Okay. Any further Commissioner discussion? Commissioner Ferguson?

DR. FERGUSON: So I presume that the office would be open to the same adjustments to the 30-day notification period?

MR. WIRTH: Yes; yup. Thank you.

MR. FALAHEE: And we'll make that a standing part of every motion for the next two. Other -- other questions? Okay.

MS. GUIDO-ALLEN: Guido-Allen. Can we accept the charges with the consensus with the Department's

recommendations and then ensure that the two charges that were not -- we did not achieve consensus on are on a workgroup for October '24?

MR. WIRTH: Yes. We can make a note that this is a priority item for the next Nursing Home workgroup or SAC.

MR. FALAHEE: Great. So then let me summarize where I think we're at. First of all, we have proposed wording in front of us that we would, if we chose to vote so forth, we would send that language out for public comment, a public hearing and to the Joint Legislative Committee, that's number one. Number two, the 30-day language as we call it would be edited just like we did a few minutes ago for the other. And number three, I think it's part of the motion to pick up on what Commissioner Guido-Allen just said is that we will make note of these charges where there wasn't consensus reached to make sure that those are brought forward in October of 2024 and then addressed going forward in the review in 2025. So those three parts to a potential motion if anyone would care to make that?

DR. FERGUSON: So moved.

MR. FALAHEE: Commissioner Ferguson makes the motion.

MS. GUIDO-ALLEN: Guido-Allen, second.

DR. ENGELHARDT-KALBFLEISCH: (indicating).

MR. FALAHEE: Guido-Allen or

Engelhardt-Kalbfleisch, either one. So one raised their hand and one "seconded."

DR. ENGELHARDT-KALBFLEISCH: It's okay.

MR. FALAHEE: Either way. Okay.

MR. WIRTH: While this motion is on the floor, I just -- I do want to make a note. Last week I got an e-mail from Arlene Elliott about there was one of the breakdowns of reformatting one of the definitions of -- I believe it was replacement beds. When we reformatted that, it changed how some people were interpreting what the definition meant, so we decided to revert back to the original. That was included in the revised packet that I sent out on Tuesday. I just wanted to make a note of that, that we're going back to how the language, the replacement beds was originally existing as it's currently effective just to avoid any confusion that might have popped up.

MR. FALAHEE: So the language that would go out for public comment includes the revert back to?

MR. WIRTH: Correct; yes.

MR. FALAHEE: Okay. All right. So I don't think we need to make any motion about that, but thank you for bringing it to our attention.

MR. WIRTH: I just wanted to make a note for everyone here.

MR. FALAHEE: Thanks, Arlene.

MR. WIRTH: Because I had a little bird pop on my shoulder, too. It's a theme of this meeting, but --

MR. FALAHEE: So -- so the motion we've got in front of us --

MR. WIRTH: It doesn't need to change. I just wanted to make sure that was noted for everyone's awareness.

MR. FALAHEE: Great. Okay. Thank you. Thank you. Okay. We have a motion on the floor. Any questions? All in favor of the motion raise your hand.

ALL: (all raise hand).

MR. FALAHEE: Okay. We have unanimous approval.

(Whereupon motion passed at 10:39 a.m.)

MR. FALAHEE: Thank you all very much. Thanks for everybody's participation on that and thanks for all the little birds that help keep the Commissioners operating and the Department operating smoothly.

Next we'll go to Psych Beds. Well, before I do that, there's a new face sitting on the other side of the Depart- -- of the table here from the Department. And Kenny or Beth, if you want to introduce Tiffani?

MR. WIRTH: Yes.

MR. FALAHEE: I was remiss in not doing that earlier. I'm sorry.

MR. WIRTH: I apologize. Yes, we have Tiffani Stanton joining us replacing Kate Tosto as our new analyst

for Commissions and Special Projects.

MS. STANTON: Hi, everyone. Tiffani Stanton. I come from LARA licensing, so I have worked here for five and a half years under health licensing for the Health Professionals and Occupational Professions. So happy to be aboard and starting a new journey. Thank you.

MR. FALAHEE: Great. And Tiffani gets the pleasure of being the timekeeper for witnesses as well. So when you see her hold up three minutes, you know you're going to get the hook pretty soon, so thank you. Thanks.

MS. STANTON: Pretty close.

MR. FALAHEE: Okay. Let's turn it over to Psych Beds. First I'll have Kenny summarize it and then a very familiar face with Dr. Jain -- there he is. And Dr. Jain is back for the 428th time to talk about Psych Beds, but it's all been very positive. So, Kenny, I'll turn it over to you or Marcus or whomever.

MR. WIRTH: I can take this one. But I do want to make note right now I don't have any blue cards for Psych Beds which is concerning because I figured I'd have a lot of blue cards for Psych Beds. So if anyone has forgotten to submit a blue card, please be sure to get that to us as soon as we can because it's a little surprising to me that we don't have any public comment on Psych Beds. Just wanted to make that note before I start.

MR. FALAHEE: It's the fear of Dr. Jain.

MS. NAGEL: Yeah.

MR. WIRTH: So we held a Psych Beds workgroup. I believe it started in the -- I think it had started in December and then we added charges at the January meeting. There was like a combination of two groups in January. And so, like, the official start was January, but there were a couple groups working on something before that, but we can say January for the start of this workgroup. So we met through to -- when was it? We met until May. And -- and this workgroup came about because there was an issue with the definition of a medical psychiatric unit. So the original task of this workgroup was to resolve that issue. But at the January meeting other iss- -- other concerns were brought up so we added to that charge a bit. And there were multiple contentious issues with this workgroup. Dr. Jain did a wonderful job of navigating all the different interests that were participating in the workgroup so I do want to make sure I shout-out to Dr. Jain for his leadership through the past must be three workgroups now I think that we've done for Psych Beds with you or --

DR. SUBODH JAIN: (inaudible).

MR. WIRTH: I'm sure there's a third coming up soon. So there are a couple items included in the workgroup report that the Department is not currently in support of.

We're not supporting a proposal that would remove limitations that currently prevent the transfer or relocation of beds approved under the high occupancy provisions before those beds are implemented. This proposal was brought out during the final workgroup meeting and consensus was not reached. The intent of the high occupancy requirements located in section eight are to grant ten-bed units to facilities that are able to demonstrate that they are currently experiencing high occupancy. The limitation on the relocation of these beds was placed to prevent facilities experiencing high occupancy from relocating those high occupancy beds out of that area in that facility. So if -- if this limitation is removed, applicant facilities who get these high occupancy beds would then be able to move them out of their high occupancy facility into a facility that's not currently experiencing high occupancy.

There's another proposal that we don't currently support. This was to reduce the minimum occupancy rate of special pool beds from the existing 80 percent minimum occupancy rate to a proposed 60 percent minimal occupancy rate. We're open to reviewing this, but we're concerned that all possible consequences of this change in policy haven't been adequately considered by the workgroup. This was presented near the end of the final workgroup meeting. We don't think it received adequate consideration before the

conclusion of the meeting. We're concerned that a reduction in the minimum occupancy rate of special pool beds from 80 percent to 60 percent could have further reaching ramifications that haven't been fully considered. We're recommending that a future workgroup or SAC look into this and consider the minimal occupancy requirements for special pool beds, whether it needs to be a blanket reduction, maybe more targeted reductions to different segments of special population pools. Those are things that we'd like to discuss and look into. We don't see this change from 80 percent to 60 percent as nontrivial and think it needs to be fully vetted before being implemented. One additional point on this. The 80 percent occupancy requirement is a maintenance volume which falls under the compliance review process within the Department.

(Off the record interruption)

MR. WIRTH: Pretend I didn't hear that. Under MCL 22247, the Department has full discretion on how to do compliance reviews and what actions to recommend. To date the Department has not asked any psychiatric hospital to de-license beds, general or special pool, due to not meeting occupancy. Even though there are hospitals that are at low occupancy, we have not asked for these beds to be returned. Additionally, the next scheduled review of Psychiatric Beds review standards is for 2024. There's going to be a public

comment period in October of this year and it'll be on your agenda for the January meeting of 2024. That's my report.

MR. FALAHEE: Great. Thank you.

MS. GUIDO-ALLEN: Commissioner Guido-Allen. I have a question.

MR. WIRTH: Yes.

MS. GUIDO-ALLEN: If indeed we have facilities that are not meeting minimum occupancy requirements with no action taken by the Department, why do we have a minimum occupancy standard?

MS. NAGEL: That's a great question. And with the -- almost every single bed standard, every single bed standard has a -- an initiation volume and a maintenance volume. And it is in the public health code that the Department has the discretion to enforce the -- the requirements of -- of a granted Certificate of Need. We typically -- what happens when we find a facility that isn't meeting, let's say in this case, that occupancy requirement, we enter into a discussion and we try to figure out the root cause. We go -- we have a wide variety of remedies that we can take up to removal of those beds. Particularly in Psych Beds, we don't want to remove. We'd love to correct. We'd love to get on a correction plan or see if there's something else the facility would like to consider. So our compliance is not cut and dry. It's not black and white. There's a

lot of gray area in it and the public health code gives the Department that discretion.

MS. GUIDO-ALLEN: Thank you. I just have concern about the 80 percent and I know that we don't want to keep talking about workforce challenges, but especially in behavioral health the workforce challenges remain significant. As the needs for behavioral health services continue to grow, the workforce challenges continue to be extremely challenging. My concern is whether they're special pool beds, special population groups or just general behavioral health, to keep an 80 percent occupancy maintenance percentage. When you may not be able to staff to that for three plus years, I just worry about that piece of it and I'd like to add a consideration.

MR. FALAHEE: And this is Falahee. Exactly. I think we all share that concern. I know the Department shares it and is sensitive to the staffing issues because they hear it every day.

MS. GUIDO-ALLEN: Every day.

MR. FALAHEE: Right. And I think, again, much like we had the discussion about the nursing home issues, probably merits further discussion. The timing is great because it comes up again in October 2023 and it'll be on the list for standards to be reviewed in 2024, so Dr. Jain will never get to leave. So, but I think it merits

discussion. I get it. Knowing the Department and where it stands, nobody is about to get yanked when they're at 71 percent and you should be at 80 and therefore we need to reduce your beds. No. That's not going to happen. But I understand the concern. Anything else? Any other questions before we turn it over to Dr. Jain? Okay. Thank you. And I joke about it, but Dr. Jain, thank you very, very, very, very much once again. You put in so many hours and deal with so many issues and then we had the gall in January to throw wild card charges at you if you remember our discussion at the January meeting. And once again you and the workgroup did stellar work. Very, very tough issue that we all are dealing with, not just in Michigan, but nationwide. So, again, heartfelt thanks to you and the members of the workgroup.

DR. SUBODH JAIN: Thank you. Very kind of you.

SUBODH JAIN, M.D.

DR. SUBODH JAIN: And, again, I'm Subodh Jain. I'm the chief of psychiatry at Corewell Health West. It's a privilege and honor to lead this workgroup and present in front of you. I would again say thank you for the opportunity, but I also thank, like, a lot of people, people who have helped me. First the Department, my friends at the Department they have often rescued me from difficult conversations with their advice and support, member of the

subgroups, the ones who have led subgroups and behind the scenes negotiations that go through sometimes very contentious issues. And part of what I also want to highlight that when we talk about contentious workgroups and people, it still had a hidden purpose and passion about mental health. That's why we are able to present today which was mostly -- well, actually, unanimously approved charges. A lot of those seemed fairly impossible at the start, but now we are here. So I'll start reading my report.

The charge first is review adding to and revising language within addendum for special population groups to allow for initiation of a freestanding med psych unit; medical psychiatric unit. So the recommendation from the workgroup is modifying the definition of medical psychiatric unit to remove reference to a patient requiring hospitalization and instead focus on the concept that medical treatment is required, providing clarification within the project delivery requirements; therefore, the units located in a freestanding medical psychiatric unit that medical treatment must not require inpatient acute care hospitalization. Modifications to the requirements for the approval and project delivery requirements for this special pool are also recommended to better define staff and services that must be provided by all med psych units. So

the rationale is that we originally allowed only med psych beds in the acute care hospitals and the CON Commission history provided by the Department made it clear that the intention of the Commission was never to require med psych beds only be used by patients requiring acute care hospitalization. As pointed out previously by Chairperson Falahee, it is very difficult to place inpatient psychiatric beds --

(Off the record interruption)

MR. FALAHEE: It's not you, Dr. Jain.

DR. SUBODH JAIN: I hope not. Fairly quickly modify the standards to allow these beds to be placed in freestanding psychiatric hospitals.

MR. FALAHEE: And, Dr. Jain, while Kenny is fixing the microphone, would you like us to stop at each charge to see if the Commissioners have questions?

DR. SUBODH JAIN: Sure. However you suggest.

MR. FALAHEE: Okay. Let's -- let's -- let's stop charge by charge. That's why when it's in front of us, I think it'd be good to have that discussion.

MR. WIRTH: Sorry, everyone. Let me give you mine, Doctor.

DR. SUBODH JAIN: So language has been added to attempt to clarify that these beds are intended for use by patients that are difficult to place into general inpatient

psychiatric bed because of their medical comorbidities without restraining their use so far as to forbid use by patients who have chronic medical conditions that truly makes it difficult to -- for them to be placed. So that's charge one. Any questions?

MR. FALAHEE: Any questions from the Commission about that? So what we're trying to do here as I understand it is we've got these freestanding medical psychiatric units and we wanted to make clear who can and who can't be in either location; is that right?

DR. SUBODH JAIN: That's correct. There was a discrepancy between the med psych language from the Commission and how the beds can be licensed through LARA. So this language has brought to bridge that gap so that whoever wants to launch those beds can actually be adequately licensed.

MR. FALAHEE: Okay. Great. Thank you.

DR. SUBODH JAIN: So it solves that problem. It was unanimously agreed upon.

MR. FALAHEE: Right. Okay. Thank you. Any -- any questions? All right.

MS. GUIDO-ALLEN: Oh, no. I have one question.

MR. FALAHEE: Sorry.

MS. GUIDO-ALLEN: LARA supports it. Laura support -- LARA, or the licensing also supports the

language?

DR. SUBODH JAIN: That's right.

MS. NAGEL: Yes.

DR. SUBODH JAIN: Thank you. Second charge was review and revise -- it is similar -- review and revise existing language within the addendum for special population groups related to medical psychiatric units in acute care settings. So the recommendation from the workgroup was modifying the definition of medical psychiatric unit to clarify that patients must have a medical comorbidity requiring treatment which allows for medical psychiatric units in licensed acute care hospitals to care for patients either do or do not require inpatient acute care. Modifications to the requirement for approval and project delivery requirements for this special pool are also recommended to better define staff and services that must be provided by all medical psychiatric units. The workgroup agreed that there was -- it was more important to clearly define the additional staff and services needed for med psych patients to ensure appropriate level of care is available at facilities utilizing these special pool beds. In addition, it was important that these revisions allow for these beds located in licensed acute care hospital to serve medical psychiatric units whether or not they require acute care hospitalization. So this was also met unanimously,

similar charge of the language change.

MR. FALAHEE: Any questions about that charge two? It's related to charge one, so it sort of go hand in hand. Okay.

DR. SUBODH JAIN: Thank you.

MR. FALAHEE: Thank you.

DR. SUBODH JAIN: The third charge was review adding provisions to improve flexibility in the use of a freestanding medical psychiatric unit to allow admission of patients not requiring medical treatments if unable to find placement. The workgroup recommends modifying the definition of medical psychiatric unit to allow a unit located in a licensed acute care hospital to use these beds for general inpatient psychiatric up to 40 percent of patient days if they follow limitations added to the project delivery requirements. The limitations proposed in the project delivery requirements allow for the use of the medical psychiatric beds by general inpatient psychiatric patients if they're presented to the acute care hospital's emergency department and the hospital was not able to place them into a general inpatient psychiatric bed within 16 miles and within six hours due to lack of available beds or medical admission criteria of the facilities where placement was attempted. A minimum of three facilities must have been attempted. Facilities utilizing the beds in this matter

must report information regarding the use of these beds for non-medical psychiatric patients in the CON annual survey. The rationale is the workgroup agreed that even a patient requiring inpatient psychiatric admission in an emergency department for more than six hours of awaiting a general psychiatric bed, if that hospital has available med psych bed on their unit, it is not in best interest of patient care. Balancing the needs of patients awaiting a bed in the ED but desire to keep as many medical psychiatric beds available for the patients with medical comorbidities resulted in the compromised language to restrict how much they can be used for non-medical psychiatric patients and what attempts need to be made to place them elsewhere.

MR. FALAHEE: Commissioner Ferguson?

DR. FERGUSON: So just a question and I don't understand all the models enough to know how this plays out. The notion of having some flexibility actually makes sense. Like how do we use our resources and be flexible? I think that's a great, great plan. Would want to make sure there's not a negative impact on patients and so my question becomes I'm taking a guess that reimbursement and/or charges structure is different for general inpatient psych versus med psych. And so if a general inpatient psych gets assigned to a med psych bed, who pays and is that going to fall to the patient? I don't want the patients to -- you

know, a general psych patient to be paying 50 percent more or whatever if that -- that's the general notion. I don't know quite how to phrase the question because I don't understand the reimbursement structure well enough.

DR. SUBODH JAIN: I'm not an expert in reimbursement structure; however, I would suggest that primarily these beds are psychiatric beds. So any time there is a pair of contract, most of the time there is a psychiatry contract and the medical services are actually on top of that. So usually the contract is like that but, again, it can be fair to pair difference in however it is structured. That's what I generally see. But as I said, I'm not an expert in that.

DR. FERGUSON: Just trying to protect the patient.

DR. SUBODH JAIN: Definitely.

MR. FALAHEE: Yeah. And this is Falahee. That's my general understanding as well how it works. And we've talked about this before, those of us that have anything to do with hospitals and emergency departments, and I know the Michigan Hospital Association tracks this. If you go to any medium or large size hospital right now, dollar to donuts there's patients waiting in the ED for a bed and there aren't any available. And so that's where I really like this -- this compromise. I think it's a great solution in the best interest of that -- that person's care so they

don't sit in a windowless room in an emergency department day after day after day. So I think, you know, I applaud the group on coming up with this compromise.

DR. ENGELHARDT-KALBFLEISCH: I have a question. Commissioner Engelhardt-Kalbfleisch. First of all thank you for all the work that you've led. In general I'm very supportive. Just a question about the six-hour time frame and, like, overnight. How did the group decide six hours? I appreciate, like, the patient care and the benefit of moving the patient out of a high acuity, stressful, loud, chaotic emergency department. I guess how did they land on six hours and was there any concern about, you know, if someone hits the emergency room at 11:00 p.m., are they going to get placed realistically by 7:00 a.m.?

DR. SUBODH JAIN: So it came from various stakeholders who have the emergency rooms. The original proposal was a little bit longer, but the idea was that within six hours with first initial social work assessment it is determined whether this will be placed or not and the most patients who do not get placed are the ones who often do not get placed. Like an easy depressed patient will be placed, however, a patient with chronic suicidal behaviors or intellectual disability or other -- other issues a patient could have --

(Off the record interruption)

MR. WIRTH: We're just going to start yelling.

MR. FALAHEE: Oh, this is Commissioner Falahee. I'll add that there is a bill in the legislature that would allow us to meet virtually, so we're working on that.

DR. SUBODH JAIN: So that was the rationale behind is how quickly can we determine whether it is the right thing to do and those patients are easily identified. I -- I do believe there was -- there was not a lot of concern from every stakeholder, even from freestanding psychiatric hospital versus the one who have emergency rooms, about the timeline. It actually was brought down by the group unanimously.

DR. ENGELHARDT-KALBFLEISCH: Thank you.

DR. SUBODH JAIN: Thank you.

DR. ENGELHARDT-KALBFLEISCH: In general I guess I am supportive. Just curious. Thank you.

DR. SUBODH JAIN: Any other questions on this one?

MR. FALAHEE: Okay. Any other questions on that? Okay. Charge four.

DR. SUBODH JAIN: So the next charge is review adding a provision to create a temporary hold on the use of bed need methodology for initiation of child and adolescent psychiatric beds while maintaining project delivery requirements. So the recommendation from the workgroup was creating a new pilot program to allow applicants seeking

child/adolescent inpatient psychiatric beds to obtain approval without regard to the bed need methodology or existing occupancy if applicable for all applications filed by July 1, 2030. All of the requirements remain in place and all facilities must meet all project delivery requirements once approved. Applicants receiving beds under this pilot must also provide an annual report to the Department to help them determine if the pilot was effective at addressing the pediatric behavior health crisis. So the rationale which was discussed prior to starting this workgroup was Michigan amongst the rest of the nation is experiencing a behavior health crisis and especially in the pediatric population. It has hit disproportionately hard here. In addition, we recognize an inherent deficiency in the psychiatric bed need methodology in that it does not contain patient origin data. This means that the methodology inherently predicts more beds needed where they already exist and struggles to predict the need in areas that are already underserved. This is particularly challenging with child and adolescent beds because there are many areas of the state where there are no beds existing at all. By creating this pilot program, providers across the state will have a window of opportunity to place beds anywhere they see a need which will allow the methodology to work better in the future. All the workgroup members agreed

that the lack of beds is generally not the cause of behavioral health crisis and more beds are generally not the ultimate solution. The pilot will ensure that CON is not a hindrance to solving a crisis.

MR. FALAHEE: Questions of the Commissioners? Commissioner Ferguson?

DR. FERGUSON: So this is bold and, you know, I know last time I spoke up and asked to be bold so thank you for going there. I guess the question for the Department to some extent is wide open at this point. Are you comfortable with wide open, not really knowing what you're going to get over the next six, seven years or not? Like I don't -- I don't know if that's problematic and all of a sudden you end up like way out of control or --

MS. NAGEL: It's a good question and one that we talked about quite a bit in the workgroup. We think that though it is wide open from a number of beds standpoint, there's two things that I think are important. One that the pilot, you know, has a beginning and an end duration and so we're comfortable with that. And, two, you know, I would -- I am not concerned about undue proliferation of child adolescent beds because there are many areas right now where providers -- there are beds available in the northern part of our state and other southern areas as well where there are beds showing currently in our bed need and no one has

implemented them. And so in a way, you know, and not being flip at all, I would love to be proven wrong. So, yeah, I think to answer your question we are comfortable with how this is written currently, especially considering that every applicant or, you know, every successful Certificate of Need awardee will have to adhere to all of the same requirements.

DR. FERGUSON: And the follow up is, is there a risk of the following scenario: presumably historically and to date there were limits on transferring beds from this mark to this market. With this wide open scenario it creates a back door opportunity to transfer beds from this market to this market because literally you can just say "not providing services here," done, and open in another market. So it gives an indirect route to a bed transfer from one market to another. I don't know if that's a problem or not. I'm simply asking, you know, trying to make sure that if we need safeguards, there's safeguards.

MS. NAGEL: No, I think that that's a -- I think that's a great point and a valid concern. And, you know, I think that the -- the beauty of this being a pilot project is that we'll have the opportunity to evaluate it. There's language written here for the Commission to review it every year. So if -- if -- if we see concerning behavior, we would bring that right away.

DR. FERGUSON: I just don't want to see

inadvertent consequence of shutting down services in certain markets because they're viewed as less lucrative or whatever and all of a sudden we're kind of shifting problem from one spot to another.

DR. SUBODH JAIN: One of the challenges is workforce in this area and that's what was also discussed, that, yes, there may be an uptick for some beds if -- if there is -- can be created that access, but I think the limited workforce can be a good balancer for such practices in theory as of now.

MR. FALAHEE: And this is Falahee. I think that to your point, Commissioner Ferguson, I appreciate the bold and I think given that it's a pilot program and it has to come back to us at least once a year, if we see games being played we can -- we can stop that. And I'm picking up on the last phrase there, "ensure the CON is not a hindrance." As chair I've had legislators approach me and say, "hey, why can't you do more about psych beds?" And I've said to them, "With the help of the Department we're doing everything we can and now here we're even going bold so that we're doing everything we can to put beds where they're needed to address this needy population; adults, adolescents, child."

DR. FERGUSON: I support bold. I'm just making sure that we've got the ramifications sorted out.

MR. FALAHEE: Nope, careful bold. Thank you.

Anything? Okay. Moving on.

DR. SUBODH JAIN: The next charge is consider creative ideas, identify ancillary issues, and identify potential solutions to improve access to psychiatric beds and services. Again, the recommendations were in these three areas, actually two areas, form a subgroup to prepare a presentation on acuity-based reimbursement to present to the Commission with a request to incorporate -- a request for legislature to pursue acuity-based reimbursement in the next reporting Joint Legislative Committee. I think Kenny explained that that could be a part of a future workgroup. The other was reduce to occupancy the requirement for special pool beds from 80 to 60 percent. I completely understand and appreciate the Department's stance on that. I think it can be looked differently, however, from a -- from a -- from a clinician's standpoint and not -- not as a part of a policymaking.

I would suggest a couple of things about this. And, you know, again, you know, with the very humble opinion. So we only had four meetings with this charge included and it was relatively towards the later part of the -- of our workgroup. The 80 percent is also of -- I -- I do not have historical knowledge how 80 percent came about, but the mathematical equation is there is a midnight rule. That means, like, if you discharge somebody at 10:00

and admit somebody next day, it is considered as a one day miss. So even if all days are full throughout the year on these special pool, you end up and with average length of stay being about nine days throughout the state, it comes out to be around 88, 89 percent. That's the 100 percent for a special pool. So keeping at 80 percent automatically is very difficult for -- for anybody who is running the special pool beds. So there are three populations which are under this consideration: intellectual disability, medical comorbidity/med psych, and geriatrics. These are all three very well in our group.

So on the other hand the general occupancy of all psychiatric beds throughout the state, as I learned doing the workgroup, is about 65 percent throughout the year. So it is harder for special pool beds to maintain 80 percent at all times. At 75-ish percent, 75 to 80 percent, that is considered as a high occupancy bed for general. However, it is considered a lower occupancy less than 80 for special pool beds. So there is that less propensity for that. So that's what I truly wanted to share that probably that 80 percent number is not truly reflective of how these beds should be used, and second is we know how difficult the workgroup and SAC formation and how time consuming it can be. If there is a method to -- to adopt a more just and reasonable number like 60 percent which is in line with

what -- what it is, that should be considered. Of course I can -- I can request to the Department separately again and work with them if there is anything that we can do so that the policies do not become a hindrance, as we say, for somebody launching. There are not a lot of people who are looking to launch special pool beds and these are the struggling populations. If you launch, we want it to be successful and not be punitive. And I -- I know Department doesn't have any intent to be punitive, but just how it reads it probably will be something to consider for the Commission and the Department. So that's -- I wanted to share that. And I think that's all we have for -- for all the charges. No, there is one more. Any questions about charge five?

MR. FALAHEE: Commissioner Macallister?

DR. MACALLISTER: Yes. Commissioner Macallister. Doctor, can you explain -- what I'm hearing on some of the charges, just, in fact, back one charge prior, the origin -- the origin data that we don't have access to and some of the other components. I'm wondering if there are some additional metrics to instead of maybe shuffle the beds and needs around a little bit better to better understand what's happening and where maybe some of the root cause of the needs are in regards to the structures that we could put in place to better track patient needs in different locations

as part of the work. Did you consider maybe adding some additional data that we -- that would help inform us what was happening more as opposed to just adjusting the response? Does that make sense?

DR. SUBODH JAIN: Yes; yes. As I understand, like, it'd be define any additional metrics that -- how are we successfully implementing these new child and adolescent. I do not think that was part of the conversation because I do believe the existing guidance from the Department we have the right metrics to track, but this is just opening up so that the CON application process and comparative reviews are not -- not the barriers to opening more child and adolescent beds. But I will defer over to the Department.

DR. MACALLISTER: Thank you.

MR. FALAHEE: Okay.

MR. WIRTH: I don't have anything additional on.

MR. FALAHEE: Okay. This is Falahee. One -- one comment on the 80 and 60 and I think this is, like, classic high school debate: tell me which side you want me to be on and I'll argue for it. I think, again, personally this is one where, much like with the Nursing Home, to be discussed in more detail later and the timing is very good for Psych Beds because it comes up for public comment this October. So to the extent there are those issues and we need to fully vet them, I think that'd be a great opportunity and then we

can look at it even in more depth next year. But I understand both sides of the argument and that's why I think a fuller discussion might be helpful.

DR. SUBODH JAIN: Thank you.

MR. FALAHEE: Other questions of Dr. Jain? Okay. Stay put. There might be public comment.

MR. WIRTH: There is one public comment.

MR. FALAHEE: Okay. Thank you.

MR. WIRTH: Melissa Reitz.

MR. FALAHEE: You can sit down, Dr. Jain. We know where you're at.

MELISSA REITZ

MS MELISSA REITZ: Good morning again -- this is still morning; right? -- yeah. Melissa Reitz with McCall Hamilton. And it's fine if it waits until next year, but I just did want to note that the -- I brought this (indicating) up here because I had to reference it, but the 80 percent occupancy requirement in the special pool is written a bit differently than the 60 and 40 percent in the regular standards. Where instead of, at least the way it's written, it would imply that there isn't discretion by the Department. It says that the applicant must -- or I think it says "applicant shall" at the end of the three years de-license beds to get them down to the 80 percent or get them up to the 80 percent occupancy. So I just -- I guess

for me that makes the reduction a bit more important if it's interpreted that way, that the Department doesn't have the discretion that they normally do in occupancy. So I just wanted to make that clear. Thank you.

MR. FALAHEE: Thank you for bringing that up. Something that we can -- let me -- let me ask it this way. Has the Department ever taken action against someone who hasn't done that?

MS. NAGEL: No.

MR. FALAHEE: I didn't think so. Okay. But maybe it's something we could look at come October or come next year.

MS. NAGEL: Absolutely.

MR. FALAHEE: Okay. All right. So no other public comment then, Kenny?

MR. WIRTH: That was the only card I had.

MR. FALAHEE: Okay. Thank you.

MR. WIRTH: And I don't see anyone jumping up so I think we're good.

MR. FALAHEE: Okay. Okay. And, again, Dr. Jain and team and workgroup, thanks again very, very much. So we have in front of us this language -- is there any other Commission discussion? Commissioner Ferguson?

DR. FERGUSON: A question. So less about the workgroup -- less about the workgroup's work which I'm

supportive of and I think a nice job has been done here. As you include in the packet the lengthy verbiage of the entire scenario, was hoping you could enlighten me and/or maybe it's a consideration for future next year whenever we look at it. Again, I don't know enough about the reimbursement structure and if cost basis is relevant to the reimbursement. If it's not, I have some apprehension about including points for cost of bed because it -- you know, I understand if it's driving up the cost because people are being paid based on their cost basis, but if they're not being paid on their cost basis, don't we want facilities willing to make it nice and put in the extras? And I know we've tried to itemize some of the extras, but to our earlier conversations it's near impossible to itemize all the extras, and do we do this in other services? Do we say, well, here's two CT scanner applications, we're going with the proposal that's the less expensive CT scanner?

MR. WIRTH: Through a comparative review.

DR. FERGUSON: Do we do that in comparative review for everything? Is cost in all of them?

MS. NAGEL: No. In the statute that created Certificate of Need it tells us specifically in comparative review some things -- some things that have to be in comparative review -- and beds are one of them -- and then some things that we specifically need to look at.

DR. FERGUSON: So we have to look at the cost?

MS. NAGEL: I don't know that we have to look at it like thi- -- I mean, I think that it's a good discussion. We could look at it a different way perhaps. But cost is something we do have to look at.

DR. FERGUSON: We can table it. I'm not -- I'm just -- I'm nervous that we're not driving what we want to drive out of this. Like I understand the intent, I'm just not sure -- I mean, I read this and I'm, like, okay, I can -- you know, can I game this? Here's the things I get a couple of points for for a nice garden or whatever and I'm going to cheap on the facility with a 15-year remodel plan rather than a 25-year remodel plan or on structural and I -- whatever.

MR. FALAHEE: Yup.

DR. FERGUSON: All right. Thanks.

MR. FALAHEE: No, I -- no. Thank you. I just understand where you're coming from. I want to see if the Department has any further comment.

MS. NAGEL: We were just discussing it. No, we don't really have any further -- I think it's a great -- I think it's something that we could certainly explore further.

DR. FERGUSON: Next year.

MR. FALAHEE: Great.

DR. FERGUSON: Thank you.

MR. FALAHEE: I, for one, appreciate anyone that looks at how to game something so we can stop the gaming if it's not appropriate. So, yeah, thank you. I was accused of that early on in my CON career, so my penalty was being put on the Commission. Okay. Any further discussion or question? All right. What we've got in front of us is much like the other two agenda items before this. We have proposed language and if we take action on the proposed action to approve it, that'll go to the public hearing and to the Joint Legislative Committee. I think what we would need would be a motion, number one, to approve the proposed language, send it to a public hearing and the Joint Legislative Committee. Number two, on the 30-day language, revert to the language we've done, the changes we made earlier today on the prior two items. I can't think if there's anything else that's needed for the motion. I think that would -- that would be the motion to take it to public hearing and JLC and to change the 30-day language like we discussed earlier. Would anyone care to make a motion to that effect?

MS. TURNER-BAILEY: I have a question the motion.

MR. FALAHEE: Yeah.

MS. TURNER-BAILEY: Commissioner Turner-Bailey. So we just had a big discussion about the charge five and

the Department said they weren't in agreement with that. So I guess I'm wondering why would we approve that language? I'm not inclined to approve that piece of the recommendation based on the comments made earlier and the fact that we just said that it's coming up for a public comment in October. So I just want to understand that better before we go make a blanket recommendation to approve the -- approve the recommendations.

MR. FALAHEE: Thank you. Good question. Kenny?

MR. WIRTH: So that 80 percent reduction down to 60 percent is -- was not included in the draft language that's in front of you right now. It's in the workgroup report, but we did not include it in the language itself. So the vote today would be to approve the draft language as presented which does not include that reduction down to 60 percent.

MS. TURNER-BAILEY: Okay. So you already made that sort of adjustment in the proposed language?

MR. WIRTH: Yes.

MS. TURNER-BAILEY: Okay.

MR. WIRTH: So that was not inclu- -- it was in the report but it was not in the language and we can make sure to add that reduction down to 60 percent or looking at special pool occupancy requirements. We can make sure that's on the report to the Commission in January for

looking at next year with the next workgroup or SAC.

MS. TURNER-BAILEY: Okay. And then there was a second one that you mentioned earlier. I don't remember. When you were going through the Department's concerns.

MR. WIRTH: That was the high occupancy, being able to relocate those beds before they're implemented.

MS. TURNER-BAILEY: Okay. And was that handled in the same manner?

MR. WIRTH: Correct. That is not included in the draft language.

MS. TURNER-BAILEY: Okay. Thank you.

MR. WIRTH: Yup.

MR. FALAHEE: Falahee. I should have made that clearer. I have the advantage of working with the Department before these meetings to know what's in and what's out of the proposed language, so I should have made it clearer.

MS. TURNER-BAILEY: Well, I look at the language but its -- it isn't always --

MR. FALAHEE: I can look at the language 20 times and the meaning changes every time I read it, so --

MR. WIRTH: I do look at it 20 times and it does change depending on the day and the time of day and how many cups of coffee I've had.

MS. TURNER-BAILEY: Thank you for the

clarification.

MR. WIRTH: Of course. Of course.

MR. FALAHEE: Okay. Great.

MS. GUIDO-ALLEN: So Guido-Allen. I guess I need a little bit more clarification.

MR. WIRTH: Yes.

MS. GUIDO-ALLEN: The 80 percent to 60 percent, the 80 percent worries me --

MR. WIRTH: Yes.

MS. GUIDO-ALLEN: -- in the special pool beds. How are -- what is the Department's clarification or support not to close beds because of the 80 percent requirement?

MR. WIRTH: We have not closed beds due to that in the past and we're not looking at doing that going forward. We are open to reviewing this occupancy maintenance volume requirement next year when it's up for review but that's not going to be included in what's on the table right now. Does that help or no?

MS. GUIDO-ALLEN: Not really.

MR. WIRTH: Okay.

MS. GUIDO-ALLEN: It's just worrisome.

MR. FALAHEE: Basically it's a trust us at this point.

MS. GUIDO-ALLEN: I know.

MR. FALAHEE: Okay. Right. So we have -- we

don't have a motion yet, but we have something to consider if anyone would care to make the motion.

DR. KONDUR: Commissioner Kondur. I'd like to carry the motion as presented.

MR. FALAHEE: Thank you. Is there support?

DR. FERGUSON: (indicating)

MR. FALAHEE: Supported by Commissioner Ferguson. Any discussion? All in favor please raise your hand.

ALL: (all raise hand).

MR. FALAHEE: Okay. Unanimous approval. Thank you very much.

(Whereupon motion passed at 11:25 a.m.)

MR. WIRTH: Thank you.

MR. FALAHEE: So it's 11:25. We probably have another 20 minutes to go my guess is. Would we want to proceed without a break and just keep going forward or do we need a break?

MS. GUIDO-ALLEN: Can we just have five? Five minutes?

MR. WIRTH: Five minutes.

MR. FALAHEE: Five minutes. Deal.

MR. WIRTH: Sure. All right. We'll resume at 11:30.

MR. FALAHEE: Great. Thank you all.

(Off the record)

MR. FALAHEE: So let's -- let's get started again. We'll get -- we'll get started again. Thank you all very much. And since we're without microphones, we'll do our best to project. And I've asked some of the people in the last row to wave their arms furiously if they can't hear us or if they don't care what we're saying, just ignore us. So thank you all. We'll do the best given the old audio technology in this room and hope that the bill that would let us do it all by Zoom goes through the legislature. So thank you. All right.

With that, the next item on the agenda, at long last after many, many, many, many years of effort is on Air Ambulance, and Kenny will explain why it's finally on here through no fault of the CON Commission.

MR. WIRTH: Yeah. I'm actually going to let -- I'm going to let Tiffani explain this one so I can take a little bit of a coffee break in between speaking and give my throat a rest, so --

MR. FALAHEE: Okay. Tiffani?

MS. STANTON: Yeah. So in 2002, the Department was notified that the Federal Aviation Administration Authorization Act (inaudible) include the CON meets determination requirements prescribed under Part 222 of the Public Health Code for Air Ambulance Services. However, the CON didn't just regulate the determination of need for Air

Ambulance, but also requirements pertaining to licensure, certification, standards and services not -- or included to but not limited to safety, equipment and staffing requirements. CON was permitted to continue the regulation of Air Ambulance until EMS could pass rules concerning the aforementioned requirements. On May 26, 2023, the updated EMS Life Support Agencies and Medical Control administrative rules became effective. These administrative rules contained the requirements that CON previously regulated. The Commission is now able to discontinue the regulation of Air Ambulance Services. If the Commission chooses to deregulate Air Ambulance Services, the Commission would take proposed action at today's meeting and move the question to deregulation to a public hearing and to the Joint Legislative Committee. The Commission can then take final action at the September Commission meeting.

MR. FALAhEE: Thank you. So basically starting in 2002, we didn't need the CON standard. It took 11 years for the necessary regulations to be drafted.

MR. WIRTH: 20- --

MR. FALAHEE: 20.

MR. WIRTH: -- 21.

MR. FALAHEE: 21. Sorry.

MR. WIRTH: Yeah.

MR. FALAHEE: Lawyers don't do math.

MR. WIRTH: Social workers don't either.

MR. FALAHEE: And trust me, I can't tell you the number of times that certain senators, former senators and current legislators have said to me, "why can't you get rid of this standard? Why do you still have it? Come on, let -- let's bring CON current." And so I'm glad that after many years, whether it's 11 or 21, who's counting, we can finally take care of that and bring us current. Is there any public comment, Kenny?

MR. WIRTH: I don't have any public comment on this. No blue cards. So I'm sure people echo our excitement for getting rid of Air Ambulance, but --

MR. FALAHEE: Mr. Walker, do you want to say anything to -- no? Thank you. All right. Any Commission discussion or questions?

DR. FERGUSON: So this is great. Glad we're finally there after 20 years. Are there any other domains that are in the works on a regulatory basis either from the feds or from state legislature or whatever that would alter other covered services?

MR. WIRTH: No.

DR. FERGUSON: Just this one?

MR. WIRTH: Yup.

DR. FERGUSON: So we got to keep showing up?

MR. WIRTH: Yup.

DR. FERGUSON: All right.

MR. FALAHEE: Yeah. Current, currently the stance of the current Governor and the majority of the legislature is very, very strongly supportive of CON. And I don't -- I do think we'll need to continue showing up, whether in person or on Zoom. So with no further discussion, Tiffani did a good job of laying out that if we choose to deregulate Air Ambulance, as now we're able to do, the Commission would take proposed action, move the question of deregulation to a public hearing and to the Joint Legislative Committee and then it would come back for final action to us at some later date. Would anyone care to make a motion to that effect?

DR. MACALLISTER: Commissioner Macallister. So moved.

MR. FALAHEE: Is there support?

DR. ENGELHARDT-KALBFLEISCH: Support. Engelhardt-Kalbfleisch.

MR. FALAHEE: Great. Thank you. There's a motion on the floor. Any discussion? Any questions? All those in favor raise your hand.

ALL: (all raise hand).

MR. FALAHEE: That motion carries unanimously.

(Whereupon motion passed at 11:37 a.m.)

MR. WIRTH: Alleluia.

MR. FALAHEE: Yeah. Okay. Moving on. Agenda

item nine is Psych Beds recalculation of psych -- the bed need numbers and setting an effective date. Kenny, now that your coffee is cooling off, proceed.

MR. WIRTH: Thank you, Mr. Chairman. And Beth and Tulika, I'll ask you to jump in whenever you'd like to. So pursuant to section 42 of the Psychiatric Beds and Services standards, the Department has recalculated the psychiatric bed need numbers. Accordingly, the Commission needs to set the effective date of the bed need numbers pursuant to section 43 of the Psychiatric Beds and Services standards. The Department is recommending an effective date of October 1st, 2023. So modifications made by the Commission pursuant to section 4, which is what your action will be today, these do not require Standard Advisory Committee action, workgroup, public hearing, or submittal of the standard to the legislature and the Governor to become effective. You'll just need to make a motion, a second, and take a vote on setting that effective date. There's a written report from Dr. Delamater in your electronic binder.

So there's -- there's an additional point here and we can discuss the numbers themselves, but I just want to make sure that all the process stuff is out on the table first. There's -- there have been questions in the past about changing the numbers for the special needs bed pools as well. So pursuant to section 3 of the Psych Beds

Services standards, the addendum for special population groups review standards, the Commission may adjust the number of beds available in the statewide pool for the needs of special population groups. And this adjustment to the number of beds is concurrent with the biannual recalculation, so the calculation that we are reporting on right now. Adjustments pursuant to this section, they recalculate the number of beds in the statewide pool through calculating a percentage of the statewide bed need for inpatient psych beds rounded up to the next ten beds with a minimum of 50. Essentially what this boils down to is that if we -- if the Commission chooses to adjust the special pool bed needs, it will be based on a percentage of the new bed need numbers and the new bed need numbers show a reduction in bed need, which I can defer to Tulika and Beth to try to explain a bit better.

MR. FALAHEE: This is Commissioner Falahee. Again, I had the advantage of talking with Kenny and the others. When they told me that the -- the new bed need numbers showed a decrease in psych beds, I went what? What are you talking about pursuant to our earlier discussions today. And the numbers are what the numbers are through Professor Delamater, but as I understand it, we're not required to adjust the percentages of the --

MR. WIRTH: Statewide special pool, correct.

MR. FALAHEE: -- special pool. We could leave those as is at X number, even if the general pool, general number went down; right?

MR. WIRTH: Correct. And we are recommending that you take no action on special pool beds to not impact those numbers.

MR. FALAHEE: Do we have to take specific action to say we're not taking action or --

MR. WIRTH: No.

MR. FALAHEE: Okay. All right. Beth, I probably honed in on something you were going to talk about so I apologize. Go ahead.

MS. NAGEL: You didn't. You didn't. That was -- that was great. I was just going to address the going down phenomenon that we're seeing. And, Tulika -- this was in the packet. Tulika made this and put this handy graph in the packet so that you could see according to this -- let me back up. Let me back up. The bed need is a combination of several different pieces of data. One is population estimates going out five years. Those come from the state demographer. The second is a base year which is the most recent year for which there is annual survey data available. That is right now 2021. What Dr. Delamater is seeing in the data is a reduction in psychiatric inpatient care in 2021. A lot of reasons for that. A lot of -- you know, perhaps

it's an anomaly, perhaps it's a blip. But when we look at what the standard says to do, it says to run this data and -- with those variables and to bring it to you and for you to set the date for which those become effective. We've picked October 1st for a couple of reasons. Normally we pick a much closer date. We picked October 1st because we are, this spring -- well, no, this spring we took on the annual survey for 2022. The data is coming back. We're looking at it. I would like to see what a 2022 base year looks like. Now, the standard doesn't say to do that, but I think it's something that we should do. We should look at a 2022 base year to see if 2021 wasn't indeed a blip, if things change for 2022 as the base year. We also put October 1 as the effective date because right now before this new data we show a need in several populations and someone could apply for those beds now before October 1 before that need essentially goes away potentially. So we're trying to give every advantage to anyone to apply for these beds and utilize the current bed need we have.

So I guess I say all that to say we're kind of in a place between what it says regulatorily we have to do, which we have brought you, and some things that I want us to keep in mind for our next Commission meeting which would be we will look at the 2022 data, see what that looks like. But in the meantime, the Commission still needs to set an

effective date for these standards. I'm sorry if that -- I feel like that was a little meandering, so I'm sorry if that wasn't clear.

DR. FERGUSON: Okay. So my sense is what you're saying is we're not sure that there's a real world diminution in need and that it might be an artifactual diminution based on peculiarities to 2021.

MS. NAGEL: Uh-huh (affirmative).

DR. FERGUSON: If that's the case, and I understand that regulatorily right now we have to act on these, do we as a Commission have the power to put forward a proposal that says we're going to skip a year?

MS. NAGEL: It's a good question. You have. The Commission has in the past on a different set of standards. I think that there was some debate. I don't know if it was ever resolved as to whether or not that was not completing all of the duties of the Commission. So I don't know that I can fully inform you on that.

MR. FALAHEE: Could we -- Falahee here. Could we set a date, not October 1 but let's say January 1 of 2024, but then that would give us chance -- we meet again in September and December, and that would give us a chance to maybe reset the date depending on what the 2022 numbers say? Because I think we all realize we know there's a need. We know there's unmet needs, go to Emergency Department A, B, C

or --

MS. GUIDO-ALLEN: This is Guido-Allen. I would rather take 2022, the last six months and annualize it because we had a surge and a half in 2022 for COVID that impacted everything. So even if you took July through December of 2022 and annualized that data to give us a better picture of what our behavioral health needs are, I would rather do that.

MS. NAGEL: I think that's a great point. I think we have to review if we can do that. So I would, if -- you know, I guess I -- I always look to Tulika. I'm not trying to mess up anything in her world by saying this, but I think the proposal for a January 1 would give us time to do that, to look at it to see, you know, if that's something we can do. Not technically, but legally something we can do.

MR. FALAHEE: Right. Tulika, does that -- and I don't want to put you on the spot. Sorry. But does that potentially work with a January 1, 2020- --

MS. BHATTACHARYA: Yes, absolutely because I know for sure we did get one application for new beds in the June window and the next comparative window will be October 1. So if the Commission decides at a minimum to put the effective date as of January of next year, so if somebody applies in October, that will give the Department, provided it's not a comparative review, to approve those projects

before the beds go away practically.

MR. FALAHEE: Okay. And then -- I know Commissioner Macallister, hold -- hold one thought. The idea that Commissioner Guido-Allen had of take the last six months of 2022, is that something you need to look at whether the Department is legally able to do that?

MS. NAGEL: Yeah; yeah.

MR. FALAHEE: So you could report back at our September meeting?

MS. NAGEL: Absolutely.

MR. FALAHEE: Because I get why you're saying that. I understand.

MS. NAGEL: Yeah.

MR. FALAHEE: Commissioner Macallister, you want to --

DR. MACALLISTER: So thank you, Chairman. I'm curious -- so given what we just talked about also with the pilot project as well, I'm wondering if that gives, like, opportunity for us to look and re-look at the needs overall for the beds as that data would come in potentially; right?

MS. NAGEL: Yeah.

DR. MACALLISTER: And so I'm wondering if it -- if it maybe is something that over the next couple years we do an annualized review of need so we can better understand and get a handle on kind of what's happening and maybe some of

the anomalies as well as the better understanding with this pilot project. That it just seems like it might be an annual thing for a little bit of time to better understand and get our -- get our arms around it.

MS. NAGEL: Yes. So part of the pilot is an annual review.

DR. MACALLISTER: Right.

MS. NAGEL: I would say that that's something we'll have to also look at because it is spelled out in the statute how often we do this specific review.

DR. MACALLISTER: Right; right. But I'm just wondering with that going on and this kind of anomaly, does it make sense to just put it all together and just look at the psych beds and at the same time annually for the next little bit so we're not precluding anything that --

MS. NAGEL: Yeah. I think what's -- I have to think through is given that the base year is the year for which we have the most recent data, it'll always be a year lagging. It will be awhile before we see the pilot --

DR. MACALLISTER: Impact.

MS. NAGEL: -- yeah.

DR. MACALLISTER: 100 percent. I get that piece. I just think that there's a lot of other contributions within kind of what's happening in the area that it might make some sense to take it a little bit more frequently than

less. We have the data and we have the access to that data. Are we impacting it?

MS. NAGEL: Yes. I think we can look at that. I think we have to look at legally how often the -- the Commission can set a new bed need.

MR. FALAHEE: And this is Falahee.

MS. BHATTACHARYA: And also that annualizing of the data. So what we have from the providers is calendar year, 12-month data. So we'll have to go back to the provider and ask for their six-month data for July through December.

DR. MACALLISTER: Uh-huh (affirmative).

MS. NAGEL: Oh, I see what you're saying.

MR. FALAHEE: Yeah; right.

MS. BHATTACHARYA: We have the total for the calendar year.

DR. MACALLISTER: The calendar year.

MR. FALAHEE: Right.

DR. MACALLISTER: But it's not broken out.

MS. BHATTACHARYA: Exactly; exactly.

DR. MACALLISTER: But we could start a tr- -- I mean, you could, if you -- if we had it, if we were allowed on an annual basis to do that, we could see the trend even if we weren't going to take the six months and not have to do the re- --

MS. GUIDO-ALLEN: Providers should request.

MS. NAGEL: To answer your question, yes, we can look at it.

DR. MACALLISTER: Uh-huh (affirmative).

MS. NAGEL: The problem is assigning it as the official bed need for the --

DR. MACALLISTER: For that, yeah; yeah.

DR. FERGUSON: So if you come back in September and say that, you know, you don't have the current authority to use a six-month annualized, I guess the other thing I would ask that you look at is do we have the authority --

DR. MACALLISTER: Right.

DR. FERGUSON: -- to grant you the authority at that time, right, to be able to make a motion or whatever and give you the authority to do that. That's the first question. Second question or it has to do with January 1st, '24 set date. Is there any requirement to do it that way and/or do we want even more breathing room and make it halfway through next year or end of -- end of '24? I mean, it depends how far you want to kick it down the road.

MR. FALAHEE: Right.

DR. FERGUSON: What I don't want to do is find ourselves chasing ourselves over and over and over where we could sort of just miss the deadline or whatever.

MR. FALAHEE: A question for the Department. How

far -- or for Attorney Heckman. How far out can we set the date?

MS. NAGEL: See that's the same question that came up. The last time this came up it was Nursing Homes. And if I recall correctly, what happened was the Commission set it six months out and then when we got to six months we still didn't have the right data, we did it again. It was a -- that was a little bit of a different situation where there wasn't, like, a pandemic anomaly, but we were getting weird data from our -- from the providers and so we had to kind of go back and correct it. So essentially what happened is, you know, the can got kicked until we had the right data.

MR. FALAHEE: Right; right. So we could -- we could initially kick it to January 1 and then if needed --

DR. MACALLISTER: Uh-huh (affirmative).

MR. FALAHEE: Okay.

DR. MACALLISTER: Extend it.

MR. FALAHEE: Yeah.

MR. WIRTH: Tulika, is -- is January 1 okay with you and your team or would it be, like, the 3rd or 5th? I know in the past we've tried January 1 on other things and we've decided to do, like, the 3rd or 5th. I don't --

MS. BHATTACHARYA: Oh, oh, oh.

MS. NAGEL: All depending on business.

MS. BHATTACHARYA: The first working day?
MR. WIRTH: Yes. Do we want it to be the first working day? Is that the 1st?
MS. BHATTACHARYA: Sure.
MS. NAGEL: Probably not.
MS. TURNER-BAILEY: No. That's the holiday.
MR. FALAHEE: Good point.
MS. BHATTACHARYA: It will probably be January 2nd.
DR. MACALLISTER: January 1st is Monday.
MR. WIRTH: Yeah, so --
MS. NAGEL: So January 2nd.
MR. WIRTH: -- January 2nd.
MR. FALAHEE: January 2nd?
MR. WIRTH: Yeah.
MR. FALAHEE: Okay.
MR. WIRTH: Just to make sure everyone's in the office and --
MR. FALAHEE: So your -- your new recommendation is and the Commission is January 2?
MR. WIRTH: January 2, yeah.
MR. FALAHEE: Okay. Is there anything else the Commission has to act on regarding this? Just the -- the date; right?
MR. WIRTH: Just the date, correct.

MR. FALAHEE: Okay. Any other questions? Comments? Okay. So we need a -- a motion should be proposed that says we set the effective date as of January 2 of 2024.

DR. MACALLISTER: Commissioner Macallister. So moved.

MR. FALAHEE: Thank you. Support?

MS. TURNER-BAILEY: Commissioner Turner-Bailey. Support.

MR. FALAHEE: Great. Motion and supported. Any discussion? All in favor of the motion raise your hand.

ALL: (all raise hand).

MR. FALAHEE: That motion carries unanimously.

(Whereupon motion passed at 11:53 a.m.)

MR. FALAHEE: Great. Thank you. Thank you for the moving and kicking the can appropriately down the road so we can get better data. Next, Kenny, legislative update?

MR. WIRTH: Yeah. I'll keep this brief. There hasn't been a lot going on in the legislature with regard to CON. There's one bill that was introduced two weeks ago, HB 4693. This bill intends to amend the Open Meetings Act to allow non-elected and non-compensated public bodies to meet remotely. If this does become law, it would allow the CON Commission to meet fully remotely via Zoom. We would not have to come into the room, deal with our AV equipment or

unmuting on our laptops and all that chaos that comes with trying to do a hybrid meeting in a building from the 70s. On top of that it would increase geographic diversity. That's one really big thing for us is it would allow people from across the state. I know we have someone here from way up north today, so I -- you know, it would make it so people wouldn't have to drive all the way to Lansing to participate in these meetings.

DR. MACALLISTER: Kenny, is there anything we can do to help support that?

MR. WIRTH: As members of the public you can reach out to your elected officials and express your interest in this bill and how you think it would be good for Michigan to have this pass through. But as the Commission I don't think the Commission can do anything to support it legislatively.

MR. HECKMAN: Correct.

DR. MACALLISTER: Thank you.

MR. WIRTH: That's it for legislative updates that I have.

MR. FALAHEE: Okay. Next our usual administrative updates and there are a few. So, Kenny?

MR. WIRTH: I'm going to have Marcus take the first three and then I can handle PET.

MR. FALAHEE: Okay.

MR. CONNOLLY: All right. Administrative updates.

NICU services, effective date for recalculated bed need. Commission does not set an effective date for the recalculated bed need. This is completed by the Department pursuant to section 3 of NICU review standards annually. The Department has set an effective date of July 1, 2023.

Next, lithotripsy. Effective date for revised factor to calculate projected procedures. The Commission does not set an effective date for the revised factor. This is typically completed by the Department every three years when the standards come up for review. The Department has set an effective date of May 11, 2023. There are no current applications pending.

Next, Open Heart Surgery. Effective date for revised utilization waits for adult and pediatric numbers. The Commission does not set an effective date for the revised factor. The Department completes this update every three years and must notify the Commission of the effective date. The Department has set an effective date of May 11, 2023. There are no current applications pending. All these reports are in your electronic binder. And with that, I'll pass it over to Kenny for an update about PET services.

MR. WIRTH: Thank you.

MR. FALAHEE: Before that, any questions? What Marcus just said it's in -- it's in our binders. It's in the summary report at the front of the binder, so -- okay.

Thank you.

MR. WIRTH: Awesome. And I -- we did receive a question from Chip when we were discussing this in our pre-meeting about setting an effective date before when we're meeting right now, but since there's no applications currently pending, this won't impact any applicants or organizations in our system. So that's why we're able to set it back then.

So if there's no questions, PET scanner services. So at the January meeting the Commission charged the Department with updating the PET review standards to reflect a technical update that the Department recommended. The most recent update of PET review standards became effective in March of this year. After further discussion, the Department is requesting that the Commission table this technical revision until the next review cycle which is 2026, as these revisions are not urgent and do not warrant a second update of the review standards within the same calendar year. There's not a required process for the Commission to follow, but since a motion was approved for the Department to revise the standard, it would be appropriate for the Commission to move to amend the motion made at the January meeting relating to PET services and to instead charge the Department with making this technical change to the standard as part of the next PET review

standards revision.

DR. FERGUSON: Can you remind us of type of technical changes?

MR. WIRTH: It was the 30-day notification to the Department which is being amended at this meeting. But since that's the only change, --

DR. FERGUSON: Okay. That's fine.

MR. WIRTH: Yeah.

MR. FALAHEE: So say again what you might want a motion to say.

MR. WIRTH: What a theoretical motion might say?

MR. FALAHEE: Yeah; correct; right.

MR. WIRTH: Yeah. Theoretically the motion might -- you know, if someone wants to make it, it might say, you know, I, so and so, move for the Commission to amend the motion made at the January meeting relating to PET services and instead charge the Department with making this change to the standard as part of the next standard revision in 2026.

MR. FALAHEE: Thank you. The next standard review in 2026?

MR. WIRTH: Yup.

MR. FALAHEE: Okay. Thank you.

MR. WIRTH: Yes.

MR. FALAHEE: Would anyone care to make that

supposed hypothetical motion?

MS. GUIDO-ALLEN: Guido-Allen. I motion -- I make the motion to accept the PET proposal as documented by the Department with the edits that we made today.

MR. WIRTH: To, yeah, to push it to 2026?

MS. GUIDO-ALLEN: Push it to 2026.

MR. WIRTH: Yes.

MR. FALAHEE: Support?

DR. FERGUSON: (indicating)

MR. FALAHEE: Commissioner Ferguson support. We'll make sure the minutes correctly reflect --

MR. WIRTH: Yes.

MR. FALAHEE: -- yes, the wording. Okay. Any questions? Any discussion? All in favor of that motion please raise your hand.

ALL: (all raise hand).

MR. FALAHEE: Motion carries unanimously. All right. Thank you.

(Whereupon motion passed at 11:59 a.m.)

MR. FALAHEE: Anything else on that, Kenny?

MR. WIRTH: Not on administrative updates, no.

MR. FALAHEE: Okay. Then we'll turn it over to Tulika for the CON Evaluation Section Update.

MS. BHATTACHARYA: Thank you, Mr. Chairman. I would like to start by saying that we did hire two new

members of the CON review organization section team. Laura Duncan is our CON review specialist for hospital side, NICU, Nursing Home Bed projects, Air Ambulance that you just voted to deregulate and Capital Expenditure. So we will welcome Laura to the Department. And also Chris Tyranski is our new CON compliance analyst. So we are almost back up to full FTE except for one.

And I apologize for the long packet because there are two packets, one for quarter one and the other one is for quarter two. As you will notice, that we continue to monitor the approved projects and appropriately allowing for extension to those that needs it and sometimes they decide they will not implement a project so those are being expired. So as of the second quarter, we are still actively following up on about 112 CON approved projects. We also completed the CT statewide compliance review. The detailed report is in your packet. Other than that, there were five others facility specific compliance actions in quarter one and four compliance action in quarter two. And the detail -- sorry, not four -- three in quarter two. The details are in your packet.

A little bit about the CT statewide compliance review. As part of the review we looked at 92 freestanding facilities and four mobile CT network, of which 40 total facilities were found to be not in compliance, 39

freestanding facility basically low volume. They are not meeting the volume requirements. And one mobile network -- there was not a volume issue, but there was a scheduling issue that they were not providing services to the host site so no scheduled basis. So the Department and the providers executed 40 settlement agreements so they have -- they now have two more years to come up to the compliance level. They will be reviewed at the end of the two year. So out of the 92 plus 4 facilities, 53 were in compliance out of the 53 freestanding facilities and three mobile networks. We also reviewed all the hospital facilities, 130 of them, and 11 host sites. All the hospitals are meeting all of their CT volume and project delivery requirements except for one that was low volume and they are under a settlement agreement now and all of the host sites met their requirements. We also reviewed the two dedicated pediatric services and one portable CT scanner service in the state. Are there any questions about the compliance reports?

DR. FERGUSON: Technical question. So a whole bunch of scanners at low volume. On that page where you identify them freestanding one, freestanding two, freestanding three, you list standards dates. I presume that's date of initial enrollment or something like that. Do they continue to live under those original standards only or do they live under updated, new standards? And if so,

why are people forever grandfathered on maybe some topics that they shouldn't be forever grandfathered on?

MS. BHATTACHARYA: So that's an excellent question, Dr. Ferguson. So legally the facilities are approved under the standards under which the application was submitted. We cannot apply a different most recent standard to the facility without another action, for example, they submitted another application or they executed a settlement agreement with the Department. So all these 40 facilities that executed the settlement agreement, that will be under the most recent standard. But as far as -- but I also want to say as far as volume, the Commission did lower the maintenance volume in the most recent standard. So although these facilities are not under the most recent standard, the Department did allow that consideration to these facilities and they still did not meet that even lowered volume in the most recent standard.

DR. FERGUSON: I guess one of the questions that I would have in follow-up is, you know, I understand the pro of not changing the rules on somebody where, like, say you've been -- you've been granted your facility or your unit or your whatever it is. It would seem to me that there -- and maybe this is a change that we have to make, maybe it's a change that the legislature has to make. I don't know who. But to be permanently grandfathered on

certain scenarios never facilitates an improvement and it may encourage somebody to show, in this case, I don't know, hang on to a machine that's archaic for no other reason that they happen to have it locked in under some old standard. I'm not saying that's what's happening here. I'm just kind of making a hypothetical. And there's a -- there's -- there's an -- there's the wrong incentive here; right? We potentially are driving the wrong process avoiding upgrades.

MR. FALAHEE: Right. This is Commissioner Falahee. I've been at this long enough to know that assistant attorney general Heckman's predecessor four times removed, Mr. Ron Stika -- and some people in this room, Walt Wheeler included, will remember Mr. Stika because he represented the CON Commission for years. And there was a question early on, late 70's or early 80's about this very thing. Like if I get a CON in 1984 under the standards in 1984 and those standards change, do I have to change with them? Answer: no. And is that right or is that wrong? But that's been the answer all along. Now, Tulika is correct. Any time there's a compliance action or a settlement agreement or a new application, for example, then we can come in and say the new standards are X and you're bound by them.

DR. FERGUSON: Well, I -- we got a lot of work in front of us. Maybe it's not a fight worth fighting, but,

boy, it'd be nice to see -- if that's the legislature's decision, it'd be nice to see whether we should change that because I think that's -- I think that's ridiculous.

MR. FALAHEE: Understood.

MS. BHATTACHARYA: If I could say two things? So actually 18 out of the 130 hospitals, although they did not have any compliance issues, they voluntarily executed a settlement agreement to come under the most recent standard. And, also, as far as, Dr. Ferguson, old machines and potential health risk, so there is no -- although the facilities are not meeting the maintenance volume and that's a violation, but if they want to replace their CT with a new one, they can do so because there is no volume requirement to replace an old CT. So the fact that they are not replacing is probably business reason.

DR. FERGUSON: But they're still living under the old standard.

DR. MACALLISTER: Yes.

MS. BHATTACHARYA: Right.

DR. FERGUSON: But, so, okay. So that may be not a good example. I'm sure there's other examples of similar notion where you're locked in under an old regulatory structure that you really want to do away with and we have no way to ever do away it with except boxing them into a settlement agreement if we can find some --

MR. FALAHEE: And I -- and I -- this is Falahee again. I will say that the Department and their compliance function has been very active in the last three or four years unlike before. They did work in compliance before, but now it's a very active compliance department and very thorough. So there are many, many more settlement agreements being signed.

DR. FERGUSON: Good.

MR. FALAHEE: Tulika, anything else?

MS. BHATTACHARYA: Oh, just quickly. The program activity report, as you will see we continue to receive a high volume of applications and thanks to our wonderful team at the Department, we managed to meet our deadlines and issue our decisions on time and expedite requests as much as we can based on the justification for -- you know, for a decision sooner than the standard time frame. I think that will be all.

MR. FALAHEE: Great. Thank you. And, again, thank you to your side of the Department. I'm glad you're almost up to full staffing. It's been hard being -- with some recent retirements and people leaving, it's been hard but they've kept up and so thank you to everyone there. So appreciate it. Next, legal activity report.

MR. HECKMAN: Assistant Attorney General Brien Heckman. The legal activity report's in the file.

Havenwyck Hospital matter has been resolved. We won on summary disposition. Havenwyck was trying to argue that because they hadn't initiated the beds that they won in the Pine Rest matter, that they were able to submit a new application which was also seeking to initiate beds at this to be built facility. The ALJ and subsequently the administrator agreed with us and the appeal period has run so this will be off the next report. Subpoena matters, just Tulika, the U.S. versus Angelo is just a custodian of records matter that Tulika is going to have to go to court on. Anybody have any questions? Okay.

MR. FALAHEE: Thank you. Kenny, any general public comment?

MR. WIRTH: I have one. And I apologize, Srirama Venkataraman (pronouncing).

MR. SRIRAMA VENKATARAMAN: So I get an automatic approval.

MR. WIRTH: From Promaxo. Yes, please come up to the podium and --

MR. SRIRAMA VENKATARAMAN: Thank you.

MR. FALAHEE: And if since we're without microphones, if you could project to the last row that would be helpful.

MR. SRIRAMA VENKATARAMAN: Definitely. I'll do my best.

MR. FALAHEE: And I don't know -- I don't know if -- I didn't announce it at the front, but witnesses have three minutes and then you get the hook from Tiffani, so --

MR. SRIRAMA VENKATARAMAN: Absolutely. I'll try to keep it short. Hopefully you can hear the back. My name is Srirama Venkataraman and I'm the chief innovation officer for Promaxo. We are a startup out of California. I have a magnet MRI system that is, that can be put in here without an issue. So I'm just going to read some statements that I prepared.

So first of all, thank you very much for the Commission and the Department to give me the opportunity to -- and Kenny for all the help. So first and foremost what I would like to clarify is our MRI system is not a 3 Tesla or a 1.5 Tesla that you have seen in a radiology facility. It is purely for interventional guidance. This is just to guide procedures. And Promaxo has basically engineered to ensure fully noninvasive experience. So there is nothing going inside the patient or, you know, irradiation from x-rays or anything. It's just radio frequency that we are exposed on a daily basis. And most importantly, this is catering to the patients who want to experience non-claustrophobic environment as it's completely an open one.

So our technology received the U.S. FDA clearance

specifically for prostate cancer, biopsies and treatment. And early studies -- that is in the packet that we provided -- provided -- demonstrated an increase of cancer detection rate of 71 percent. This is surpassing all the existing detection rate which is traditionally transferred with ultrasound and then fusion biopsy. Everything is ultrasound based which is invasive particularly with the probe in the rectum where about 80 percent of the men don't prefer it. And most importantly, the Promaxo detected 23 percent more high grade cancers, 33 percent increased accuracy, and most importantly the field strength is 50 times lower than a pre-Tesla system. So as I said, it can be brought in here, no extra construction required and the project cost is, you know, less than a million dollars or it's about less than actually three, four million dollars. So first and most importantly, we are priced, as I said, you know, one-fourth of the price of the pre-Tesla system and it's affordable, and the idea is to bring it to the community and, you know, underserved population as to the other communities where MRIs are unaffordable. Thank you very much for your attention. Any questions?

MR. FALAHEE: Thank you. Any questions? Thank you very much. Appreciate it.

MR. SRIRAMA VENKATARAMAN: Thank you.

MR. FALAHEE: Any other public comment?

MR. WIRTH: No. I don't have any. And I'll add that MRI is up next year so there will be a public comment period in the fall in October so we'll have you back then for some more information on that and we can make sure that this is on any charge for a workgroup to look at is this system an MRI, does it fit with our standards, how does that look. So we can look into that next year, too.

MR. FALAHEE: Great. Thank you. All right. Review of Commission work plan.

MR. WIRTH: I'm ready. So out of this meeting we're going to hold a public hearing probably near the end of July. That hearing is going to include Air Ambulance, CT, Nursing Home and Psych Beds after all the action that was taken today. After that public hearing we'll also transmit it to the legislature, we'll bring it back in September for final action on all of them or modifications and proposed action again if you want to change something. Those are the revisions. I'll add a slot for Air Ambulance since that isn't currently on our work plan, so you'll see that added in there and we'll start getting that ball rolling on deregulation as well, so --

MR. FALAHEE: And you need the Commission to approve the work plan; correct?

MR. WIRTH: As modified today, correct.

MR. FALAHEE: Okay. Is there a motion to approve

the work plan as modified today?

MS. GUIDO-ALLEN: Motion. Guido-Allen.

MR. FALAHEE: Great.

DR. ENGELHARDT-KALBFLEISCH: Second. Engelhardt-Kalbfleisch.

MR. FALAHEE: Great. Thanks. Any discussion? All in favor of the motion raise your hand.

ALL: (all raise hand)

MR. FALAHEE: Okay. Carries.

(Whereupon motion passed at 12:16 p.m.)

JUDGE SMITH: All right. Last, future meeting dates for this year: September 14 and December 7. If at the September meeting you could give us the dates for 2024, that would be very helpful.

MR. WIRTH: Yup. We'll have those ready for approval.

MR. FALAHEE: Okay. Great. Thank you. With that, seeing no objection or hearing no objection, I'll declare the meeting adjourned. Thank you, everyone, for your participation. Have a great summer 'til we see you in September.

MS. GUIDO-ALLEN: Motion to adjourn.

MR. FALAHEE: Oh, we need a motion? All right.

DR. FERGUSON: Second.

MR. FALAHEE: Motion to adjourn.

MR. WIRTH: Guido-Allen, Ferguson second, everyone agrees.

MR. FALAHEE: All in favor say "aye."

ALL: Aye.

MR. FALAHEE: Thank you all. Thank you.

(Proceedings concluded at 12:16 p.m.)

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CERTIFICATE

I, Marcy A. Klingshirn, a Certified Electronic Recorder and Notary Public within and for the State of Michigan, do hereby certify:

That this transcript, consisting of 116 pages, is a complete, true, and correct record given in this meeting on June 15th, 2023.

I further certify that I am not related to any of the parties to this action by blood or marriage; and that I am not interested in the outcome of this matter, financial or otherwise.

IN WITNESS THEREOF, I have hereunto set my hand this 29th day of June, 2023.

Marcy A. Klingshirn, CER 6924
Notary Public, State of Michigan
County of Eaton
My commission expires: March 30, 2029